

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06378

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06384

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR	
MARY				VIOLA	ADAMS	MAY Month 19 Day 68 Year 2:15A M				
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR	
FEMALE		WHITE		JUNE 18, 1900			67 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
MARYLAND		U.S.A.				ALLEGANY Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
CUMBERLAND			MEMORIAL HOSPITAL			Housewife			Own home	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
W. VA.			MINERAL		Fort Ashby		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Baker Rd. Rt. 1 Ridgeley,	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
GEORGE M. FISHER			MINERVA Stevenson							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
No			None		MEMORIAL HOSPITAL, CUMBERLAND, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Artery Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerosis</u>									DUE TO, OR AS A CONSEQUENCE OF	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
4301 <u>Diabetes mellitus</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>5-4</u> , 19 <u>68</u> , to <u>5-19</u> , 19 <u>68</u> , that (I) (we) lost the deceased on <u>5/19</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>William P. James</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED <u>5/22/68</u>				
22d. PHYSICIAN'S NAME (Type) <u>DR. W.P. JAMES</u>						22e. ADDRESS <u>441 N. CENTRE ST. CUMBERLAND, MD.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial			5/22/68		Fort Ashby Cem.		Fort Ashby, Mineral, W. Va.			
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE		
H. Wayne George Cumberland, Maryland						MAY 27 1968		Charles Judge		

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) CALEB H. ALLEN			2a. DATE OF DEATH Month MAY Day 5 Year 1968			2b. HOUR 11:45 P.					
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH APRIL 1, 1891		6. AGE (In years lost birthday) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS. HOURS MIN. 	
7a. BIRTHPLACE (State or foreign country) WEST VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md.					
10. CITY OR TOWN OF DEATH CUMBERLAND, MD.			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Engineer			12b. KIND OF BUSINESS OR INDUSTRY B&ORR		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE PENNA.			13b. COUNTY BEDFORD		13c. CITY OR TOWN HYNDMAN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER P.O. BOX 344		
14. FATHER'S NAME First Middle Last CALEB W. ALLEN			15. MOTHER'S MAIDEN NAME First Middle Last DINANTIA FOSTER								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) No			16b. SOCIAL SECURITY NO. 705-09-2377		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) acute posterior infarct DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Artery Disease 5221										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 hrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 4201											
19a. DATE OF OPERATION —			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? —			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. — Month — Day — Year 19 P.M. —			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) —					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) —			21f. LOCATION Street or R.F.D. No. City or Town County State —					
22a. I certify that (I) (this hospital) attended the deceased from 5/3/68 , 19 — , to 5/5/68 , 19 — , that (I) (we) last saw the deceased alive on 5/3/68 , 19 — , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE DR. R.J. WILLIAMS						DECEASED ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 5/6/68			
22d. PHYSICIAN'S NAME (Type) DR. R.J. WILLIAMS						22e. ADDRESS 122 SO. CENTRE STREET, CUMBERLAND, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE May 9, 1968		23c. NAME OF CEMETERY OR CREMATORY Hyndman Cemetery		23d. LOCATION (City or Town) (County) (State) Hyndman, Pa. Bedford Co. MD.				
24. FUNERAL DIRECTOR ADDRESS Harvey H. Zeigler, Hyndman, Pa.						25a. REC'D BY REGISTRAR DATE MAY 13 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06380

06386

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			Month Day Year			2b. HOUR			
HARMON			JEROME			ARNOLD			May 11, 1968			9:00 P M			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD			2d. HOUR				
MALE	WHITE	JAN. 28, 1916	52 YRS.	MONTHS	DAYS	HOURS	MIN.	May 11, 1968			9:00 P M				
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			Md.			
BARTON, MD.			U.S.A.						ALLEGANY						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY						
FROSTBURG			Miners Hospital--DOA			PLUMBER			PLUMBING						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET AND NUMBER			
MARYLAND			ALLEGANY			FROSTBURG			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			40 MAPLE STREET			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME												
HARMON B.			DELIA			MONAHAN									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS						
YES			W.W.II			216-10-1879			MRS. HARMON J. ARNOLD			40 MAPLE ST.,			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY:												SUDDEN			
IMMEDIATE CAUSE (a) CORONARY OCCLUSION															
4109 DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.															
(b) CORONARY THROMBOSIS															
DUE TO, OR AS A CONSEQUENCE OF															
(c) Coronary Sclerosis															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)															
4201															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?							
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
				HOUR A.M. P.M. 19											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE <i>Benedict Skitarelic</i> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>									
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>									
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> MAY 11, 1968									
						ADDRESS (Street, city, town, or county) CUMBERLAND, MARYLAND									
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)			
BURIAL				May 16, 1968				SUNSET MEMORIAL PARK				CUMBERLAND ALLEGANY, MD.			
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE							
M. SOWERS, HAFER-SOWERS FUNERAL HOME, 60 W. MAIN, FROSTBURG				MAY 17 1968				<i>Charles Judge</i>							

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FOR STATE HEALTH DEPT.

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<div>06381</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>06387</div>															
1. DECEASED-NAME (Type or Print) MAJOR ^{First} CLAY ^{Middle} ASHBY ^{Last}						2a. DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> MAY 29 19 68 2b. HOUR 8:00 ^a ^M									
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH AUG. 11, 1905		6. AGE (In years last birthday) 62 YRS.		IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>		2c. DATE PRONOUNCED DEAD MAY 29 19 68 2d. HOUR 8:00 ^a ^M					
7a. BIRTHPLACE (State or foreign country) W. Va.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH ALLEGANY ^{Md.}						
10. CITY OR TOWN OF DEATH MOSCOW MILLS Md.				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Rt. 1 BARTON, Md.				12a. USUAL OCCUPATION (Kind of work done during most of life, even if retired.) LABORER		12b. KIND OF BUSINESS OR INDUSTRY PAPER MILL					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland						13b. COUNTY ALLEGANY		13c. STREET AND NUMBER Rt. 1, Barton, Md.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>					
14. FATHER'S NAME ^{First} Randolph ^{Middle} Ashby ^{Last}				15. MOTHER'S MAIDEN NAME ^{First} Roberta ^{Middle} Dawson ^{Last}											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16b. SOCIAL SECURITY NO. 215 10 4409				17. INFORMANT James Ashby ADDRESS Box 102, Barton, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 Coronary Occlusion DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4201															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year 19 HOUR A.M. P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE Benedict Skitarelis EXAMINER'S NAME (Type) BENEDIOT SKITARELIO M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) CUMBERLAND, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE JUNE 1, 1968				23c. NAME OF CEMETERY OR CREMATORY LAUREL HILL CEM.				23d. LOCATION (City or Town) (County) (State) MOSCOW MILLS ALLEGANY Md.			
24. FUNERAL DIRECTOR Westernport, Md.						25a. REC'D BY REGISTRAR JUN 3 1968		25b. REGISTRAR'S SIGNATURE Charles Judge							

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11.13.22

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 15-71
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
BARNHART			JOSEPH W.			Month Day Year 05 07 68			10:45 AM
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR
MALE		WHITE		10-17-15			52 YRS.		MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
MARYLAND		USA				ALLEGANY Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
CUMBERLAND			SACRED HEART HOSPITAL			LABORER		CITY OF CUMB	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
MARYLAND			ALLEGANY		CUMBERLAND		XX		120 SEYMOUR STREET
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
JOESPH WALTER BARNHART			ELVA ECKHAOW						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
NO			214-07-6354		HOSPITAL RECORD, 900 SETON DR., CUMB., MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Cause of the pneumonia</u>									<u>Small</u>
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) _____									
DUE TO, OR AS A CONSEQUENCE OF									
(c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
<u>157X</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>4-6-</u> , 19 <u>68</u> , to <u>5-7-</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>5-6-</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>L. Lewis Brings</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>								22c. DATE SIGNED <u>5-13-68</u>	
22d. PHYSICIAN'S NAME (Type) <u>DR. LEWIS BRINGS</u>								22e. ADDRESS <u>57 GREENE ST., CUMB., MD., 21502</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
<u>Burial</u>		<u>May 10, 1968</u>		<u>St. Mary's Cemetery</u>		<u>Cumberland, Allegany, Md.</u>			
24. FUNERAL DIRECTOR ADDRESS <u>SCARPELLI FUNERAL HOME 108 VIRGINIA AVE., CUMB.</u>						25a. RECD BY REGISTRAR DATE <u>MAY 15 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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JOSEPH WALTER 10-17-12 02 07 08 10:25

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ALLEGY 120 ALLEGY

CHURCHLAND 2/25/52 HOSPITAL RECORD 1A-03F CITY OF CUM

ALLEGY 120 25-10-12 STREET

JOSEPH WALTER 10-17-12 02 07 08 10:25

10 25-10-12 HOSPITAL RECORD 1A-03F CITY OF CUM

SCOTT'S BUREAU OF RECORDS AND INFORMATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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06383				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				06389			
1. DECEASED-NAME (Type or print)				First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR 2:05P	
THOMAS				OLIVER	BEACHY		05	17	68		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 04-23-08			6. AGE (In years last birthday) 60 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S. A.		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY COUNTY Md.					
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) RAILROADER			12b. KIND OF BUSINESS OR INDUSTRY RAILROAD			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN CRESAPTOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER BOX 153			
14. FATHER'S NAME First Middle Last OLIVER BEACHY		15. MOTHER'S MAIDEN NAME First Middle Last ARLETTA THOMAS									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) YES 1942-1945		16b. SOCIAL SECURITY NO. 568-03-0432		17. INFORMANT Address HOSPITAL RECORD, 900 SETON DRIVE, CUMB., MD.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFRACTION 4109 DUE TO, OR AS A CONSEQUENCE OF CORONARY HEART DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 DAYS 3 YEARS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4201 CHOLECYSTITIS											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 5 - 9, 1968, to 5 - 17, 1968, that (I) (we) last saw the deceased alive on 5 - 17, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE R.W. Ballin M.D.						22c. DATE SIGNED 5-18-68			22d. PHYSICIAN'S NAME (Type) R.W. BALLIN, M.D.		
22e. ADDRESS 62 GREENE STREET, CUMBERLAND, MARYLAND						22f. ADDRESS 21502					
23a. BURIAL, CREMATION, or other disposition (Specify)		23b. DATE 5/20/68		23c. NAME OF CEMETERY OR CREMATORY FROSTBURG MEM. PARK		23d. LOCATION (City or Town) (County) (State) FROSTBURG, ALLEGANY, MD.					
24. FUNERAL DIRECTOR MARILOU M. SOWERS SOWERS FUNERAL HOME, 60 W. MAIN STREET, FROSTBURG, MD.						25a. REC'D BY REGISTRAR DATE MAY 22 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

209ERS FULLER, HOF, 9 W. 11TH STREET FIRST.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR M		
W. STONER		W.	STONER	BEGGS	May 14 1968				
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH OCT. 15th, 1889		6. AGE (In years last birthday) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md.			
10. CITY OR TOWN OF DEATH FROSTBURG.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MINERS HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) SUPERVISOR-BILLING		12b. KIND OF BUSINESS OR INDUSTRY B&O R.R.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN MT. SAVAGE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER CHURCH HILL	
14. FATHER'S NAME JOHN		15. MOTHER'S MAIDEN NAME MARTHA STONER							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. 705-05-8040		17. INFORMANT MRS. LENA K. BEGGS, MT. SAVAGE, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Advanced Hypertensive Arteriosclerotic</u> <u>4120</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <u>443X</u> <u>NONE</u>									
19a. DATE OF OPERATION <u>NONE</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>✓</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>✓</u>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>✓</u> 19 <u>68</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <u>✓</u>					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <u>✓</u>		21f. LOCATION Street or R.F.D. No. City or Town County State <u>✓</u>					
22a. I certify that (I) (this hospital) attended the deceased from <u>SEPT. 1967</u> , to <u>5/14, 1968</u> , that (I) (we) lost the deceased alive on <u>5/14, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Martin Rothstein</u>		DEGREE <u>MD</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>5/16/68</u>			
22d. PHYSICIAN'S NAME (Type) MARTIN ROTHSTEIN, M. D.		22e. ADDRESS 48 BROADWAY, FROSTBURG, MD. 21532							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE MAY 17 '68		23c. NAME OF CEMETERY OR CREMATORY ST. GEORGE EPIS. CEMETERY		23d. LOCATION (City or Town) (County) (State) MT. SAVAGE, MD.			
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR., FROSTBURG, MD. 21532		ADDRESS		25a. REC'D BY REGISTRAR DATE MAY 20 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201															
CERTIFICATE OF DEATH															
1. DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH Month Day Year		2b. HOUR				
Martha					Blair				5/25/1968		6.A-M.				
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Female			White			5/22/1884			84 YRS.						
7a. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			7b. CITIZEN OF WHAT COUNTRY?			9. COUNTY OF DEATH									
Maryland (country)			USA.			Allegany			Md.						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY						
Midland						None									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER			
MD.			Allegany			Midland			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			---			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME												
John Retallic			Rhoda Hocking												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address						
No						Mrs. Aleda Wilson,			Midland, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary insufficiency DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerosis										1 hr. years years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.			City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from May 1968, to May 25 1968, that (I) (we) last saw the deceased alive on May 25 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE			22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS						
L.R. MILES JR M.D.			5-27-68			LONA CONING MD 21539									
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)						
Burial			5/28/1968			Memorial Park			Frostburg, Md.						
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE									
George Eichhorn			Lonaconing, Md.			DATE MAY 29 1968			[Signature]						

• *Journal of the American Academy of Child and Adolescent Psychiatry*

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Wm. A. Wilson, Jr.
(President)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Jean Nicholas Bourckel						May Month 15 Day 1968 Year			4 P M
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS
Male		White		July 7, 1882			85 YRS.		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Luxenburg		USA				Allegany Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
Cumberland, Md.			Cumberland Nursing Center			Retired Conductor			Railroad
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.				13b. COUNTY Allegany		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		125 Oak Street	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Unknown			Unknown						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
No					Eugene D. Bourckel, Baltimore, Md. Son				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thrombosis</u> <u>428X</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Myocarditis & Decompensation</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerosis</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 wks</u> <u>4 mo</u> <u>5 yr</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>4221</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>April 1, 1968</u> , to <u>May 15, 1968</u> , that (I) (we) last saw the deceased alive on <u>May 14, 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Clay E. Durrett</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>								22c. DATE SIGNED May 16, 1968	
22d. PHYSICIAN'S NAME (Type) Dr. Clay E. Durrett, M.D.				22e. ADDRESS 236 Virginia Ave., Cumberland, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		May 18, 1968		Barrett Chapel Cemetery		Fredericka, Delaware			
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.				25a. REC'D BY REGISTRAR DATE May 21 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

00332

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Handwritten notes, possibly bleed-through from the reverse side of the page. The text is illegible due to fading and bleed-through.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 115
30M REV. 7-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06387

06393

1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
ANDREW				BRODE	Month Day Year MAY, 13th, 1968		12:10 P.	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
MALE	WHITE		OCT. 7TH, 1893		74 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
MARYLAND		U.S.A.				ALLEGANY Md.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
FROSTBURG		MINERS HOSPITAL		LABORER		BRICK PLANT		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
MARYLAND		ALLEGANY		FROSTBURG				266 WELSH HILL
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME						
First Middle Last ANDREW BRODE		First Middle Last JEANETTE HILL						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Address MRS. JANE L. BRODE, 266 WELSH HILL, F'BG., MD.				
		220-16-7002-A						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio-sclerotic heart disease</u> 4129 DUE TO, OR AS A CONSEQUENCE OF <u>Grand-Mal Epilepsy</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Silicosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>None</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u> <u>10 years</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>4200 None</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>6-1</u> , 19 <u>58</u> , to <u>5-13</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>5-13</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>H.C. Diehl, M.D.</u> DEGREE <u>M.D.</u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED <u>5/14/68</u>		
22d. PHYSICIAN'S NAME (Type) H. C. DIEHL,						22e. ADDRESS 39 W. MAIN ST., FROSTBURG, MD.		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
BURIAL		5-16-68		FROSTBURG MEMORIAL PARK		FROSTBURG, ALLEGANY, MD.		
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR., FROSTBURG, MD. 21532				25a. REC'D BY REGISTRAR DATE MAY 16 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

MEDICAL CERTIFICATION

48384

RECEIVED

18530



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
CERTIFICATE OF DEATH																	
1. DECEASED-NAME (Type or print)			First Letta			Middle Adella			Last Buckingham			2a. DATE OF DEATH Month 5 Day 22 Year 68			2b. HOUR P. 2:25 M.		
3. SEX Female			4. RACE White			5. DATE OF BIRTH 10/18/1890			6. AGE (In years last birthday) 77 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			IF UNDER 24 HRS.		
7a. BIRTHPLACE (State or foreign country) Pennsylvania			7b. CITIZEN OF WHAT COUNTRY? U.S.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Allegany County Md.								
10. CITY OR TOWN OF DEATH Cumberland			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Allegany County Infirmary			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Practical Nurse			12b. KIND OF BUSINESS OR INDUSTRY Nursing Prof.								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Allegany			13c. CITY OR TOWN Cresaptown			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER Box 246 McMullen Hwy.					
14. FATHER'S NAME First John Middle W. Last Robb			15. MOTHER'S MAIDEN NAME First Alice Middle E. Last Catherman			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No			16b. SOCIAL SECURITY NO. 218 12 7477			17. INFORMANT Address P.O. Box 599 Allegany County Inf.-Furnace St. ext. records					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from 3/27/67, 1967, to 5/22, 1967, that (I) (we) lost saw the deceased alive on 5/22 1967, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE George M. Simons			DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED								
22d. PHYSICIAN'S NAME (Type) Dr. George Simons M.D.			22e. ADDRESS Memorial Hospital, Cumberland, Md.														
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 5/25/68			23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery			23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany Md.								
24. FUNERAL DIRECTOR H. Wayne George Cumberland, Maryland			ADDRESS			25a. REC'D BY REGISTRAR DATE MAY 28 1968			25b. REGISTRAR'S SIGNATURE Charles Judge								

08384

CERTIFICATE OF DEATH

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06389										06395														
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										CERTIFICATE OF DEATH														
1. DECEASED-NAME (Type or print) ISABEL					First O. Middle CHATAIN Last					2a. DATE OF DEATH Month MAY Day 4 Year 1968					2b. HOUR 5:35PM									
3. SEX FEMALE					4. RACE WHITE					5. DATE OF BIRTH 11-4-1895					6. AGE (In years last birthday) 72 YRS.					IF UNDER 1 YEAR MONTHS 72 DAYS 72 HOURS 72 MIN.				
7a. BIRTHPLACE (State or foreign country) MARYLAND					7b. CITIZEN OF WHAT COUNTRY? U.S.A.					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH ALLEGANY Md.									
10. CITY OR TOWN OF DEATH CUMBERLAND					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife					12b. KIND OF BUSINESS OR INDUSTRY									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE PA.					13b. COUNTY Bedford					13c. CITY OR TOWN HYNDMAN					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					13e. STREET AND NUMBER RT.#1				
14. FATHER'S NAME First SYLVESTER Middle EMERICK Last					15. MOTHER'S MAIDEN NAME First JEANETTE Middle SPEELMAN Last																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or (unknown) No (If yes give war or dates of service)					16b. SOCIAL SECURITY NO. 218-38-759					17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction, subacute 410.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) Generalized arteriosclerosis															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1-2 weeks?									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 4201 Cerebral arteriosclerosis																								
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)														
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State														
22a. I certify that (I) (this hospital) attended the deceased from 4/28 , 19 68 , to 5/4 , 19 68 , that (I) (we) last saw the deceased alive on 5/4 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.																								
22b. SIGNATURE [Signature]										DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>					22c. DATE SIGNED 5/6/68									
22d. PHYSICIAN'S NAME (Type) DR. S.G. WEISMAN										22e. ADDRESS CUMBERLAND, MD.														
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE May 7, 1968					23c. NAME OF CEMETERY OR CREMATORY Hyndman Cemetery					23d. LOCATION (City or Town) (County) (State) Hyndman, Bedford Co., Pa.									
24. FUNERAL DIRECTOR Harvey H. Zeigler, Hyndman, Pa.										25a. REC'D BY REGISTRAR DATE MAY 13 1968					25b. REGISTRAR'S SIGNATURE [Signature]									

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MEMORIAL HOSPITAL, INDIANAPOLIS, IND.

DR. S.G. WEISSMAN

INDIANAPOLIS, IND.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
30M REV. 1-7-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06390		06398	
1. DECEASED-NAME (Type or print) First Middle Last BROOKS H. ARVEY CLAYTON			2a. DATE OF DEATH Month Day Year 5 19 68
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH 12-29-10	6. AGE (In years last birthday) YRS. 57
7a. BIRTHPLACE (State or foreign country) WEST VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street and city) SACRED HEART HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) DAIRY PLANT
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY ALLEGANY	13c. CITY OR TOWN Cresaptown
14. FATHER'S NAME First Middle Last GEORGE CLAYTON		15. MOTHER'S MAIDEN NAME First Middle Last BARKLY CARRIE CLAYTON	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (NO known) (If yes give war or dates of service) NO		16b. SOCIAL SECURITY NO. 214-16-2901	
17. INFORMANT Address SACRED HEART HOSPITAL-900 SETON DRIVE CUMBERLAND, MARYLAND.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA KIDNEY FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) Lower nephron nephrosis DUE TO, OR AS A CONSEQUENCE OF (c) Congestive Heart Failure + Pyelonephritis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 581x 591x	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) arteriosclerosis arteriosclerotic heart disease Diabetes Gout			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 1B.)
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 5/19/68 to 5/19/68 , that (I) (we) last saw the deceased alive on 5/19/68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE S. Weissman		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 5/19/68
22d. PHYSICIAN'S NAME (Type) DR. S. S. WEISMAN		22e. ADDRESS 59 GREENE ST-CUMBERLAND, MARYLAND 21502	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 5/22/68	23c. NAME OF CEMETERY OR CREMATORY St. Ambrose Catholic Cem.	23d. LOCATION (City or Town) (County) (State) Cresaptown, Allegany, Md.
24. FUNERAL DIRECTOR GEORGE FUNERAL HOME-202 GREENE-CUMBERLAND, MD H. Wayne George		25a. REC'D BY REGISTRAR MAY 27 1968	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR 1-5 (1)
30M REV. 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) MATTHEW BERNARD CORRIGAN			2a. DATE OF DEATH Month 05 Day 01 Year 68			2b. HOUR 12:55 PM							
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 04-24-1899		6. AGE (In years lost birthday) 69 YRS.		IF UNDER 1 YEAR MONTHS 00 DAYS 00		IF UNDER 24 HRS. HOURS 00 MIN. 00			
7a. BIRTHPLACE (State or foreign country) PENNA.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY COUNTY Md.							
10. CITY OR TOWN OF DEATH CUMBERLAND			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACREDHEART, HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) Retired R.R. Worker			12b. KIND OF BUSINESS OR INDUSTRY W. Md. RR				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 521 ROSE HILL AVENUE				
14. FATHER'S NAME First Middle Last MATTHEW B. CORRIGAN SR.			15. MOTHER'S MAIDEN NAME First Middle Last ELIZABETH J. Roland										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) YES			16b. SOCIAL SECURITY NO. 214-07-5032		17. INFORMANT Address HOSPITAL RECORD, 900 SETON DR., CUMB. MD.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cirrhosis of the Liver 571.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: 581.0 (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Unknown			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Pulmonary fibrosis + emphysema manicotti avenue cardiac disease													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 5/25, 1968 , to 5/1, 1968 , that (I) (we) lost saw the deceased alive on 5/1, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE S. G. WEISMAN										DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 2 May 1968	
22d. PHYSICIAN'S NAME (Type) S. G. WEISMAN, M.D.			22e. ADDRESS										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 5/4/68		23c. NAME OF CEMETERY OR CREMATORY St. Patrick's Cem.			23d. LOCATION (City or Town) (County) (State) Cumberland MD.					
24. FUNERAL DIRECTOR Louis Stein Inc., Cumb. MD.			ADDRESS			25a. REC'D BY REGISTRAR DATE MAY 6 1968		25b. REGISTRAR'S SIGNATURE Charles Judge					

00000

YES 214-07-2032 HOSPITAL RECORD, 300 STON DR., COND. NO.
NATHAN CORRIAN SR. ELIZABETH
HAYLAND ALLEGIAN CULBERTSON X 251 ROSE HILL WILSON
CONFIDENTIAL STORCHHEIT, JOSEPH
SERIAL 1121
FILE WHITE 01-24-1000
NATHAN BERNARD CORRIAN, JR. 02 01 03 12:52 P

S. C. WEISLER, N.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) First Middle Last Charles Vernon Crock						2a. DATE OF DEATH Month Day Year May 8, 1968			2b. HOUR 5 p.m.		
3. SEX Male		4. RACE White		5. DATE OF BIRTH April 21, 1896			6. AGE (In years last birthday) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Allegany Md.					
10. CITY OR TOWN OF DEATH Frostburg			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Miners Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired - Carpenter			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Allegany		13c. CITY OR TOWN Oldtown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Route # 1		
14. FATHER'S NAME First Middle Last John Crock				15. MOTHER'S MAIDEN NAME First Middle Last Susan Kerns							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) No				16b. SOCIAL SECURITY NO. 220-16-5930		17. INFORMANT Address Edna Hartman Crock, Rt. #1, Oldtown, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Ischemia 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4201 (b) Coronary Insufficiency DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mos.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) Generalized Arteriosclerosis											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased, from May 6, 1968 , to May 8, 1968 that (I) (we) lost the deceased alive on May 8, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Stanley J. Miles DEGREE M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED 5.9.68					
22d. PHYSICIAN'S NAME (Type) L.R. MILES, JR., M.D.						22e. ADDRESS LONA CONING MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/11/68		23c. NAME OF CEMETERY OR CREMATORY Bestlawn Mem. Gardens		23d. LOCATION (City or Town) (County) (State) LaVale, Allegany, Maryland					
24. FUNERAL DIRECTOR Charles E. Harer ADDRESS 290 Baltimore Ave, Cumb, Md.						25a. REC'D BY REGISTRAR MAY 13 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

02333

RECEIVED

02333

UNITED STATES DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT
WASHINGTON, D. C. 20250
OFFICE OF THE ASSISTANT ATTORNEY GENERAL
WASHINGTON, D. C. 20540
MAY 19 1964
TO: DIRECTOR, BUREAU OF LAND MANAGEMENT
FROM: ASSISTANT ATTORNEY GENERAL
SUBJECT: [Illegible]

[Illegible handwritten text]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06399

06399

1. DECEASED-NAME (Type or print) <i>Mary</i>			First <i>Ann</i>			Middle <i>Crone</i>			Last			2a. DATE OF DEATH Month <i>May</i> , Day <i>4</i> , Year <i>68</i>			2b. HOUR <i>8:00</i> A.M.		
3. SEX <i>Female</i>			4. RACE <i>White</i>			5. DATE OF BIRTH <i>July 17, 1874</i>			6. AGE (In years last birthday) <i>93</i> YRS.			IF UNDER 1 YEAR MONTHS <i>0</i> DAYS <i>0</i>			IF UNDER 24 HRS. HOURS <i>0</i> MIN. <i>0</i>		
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>			7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>			B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>Allegany</i> Md.								
10. CITY OR TOWN OF DEATH <i>Frostburg,</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Miners Hosp.</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>housewife,</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i>								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>			13b. COUNTY <i>Allegany</i>			13c. CITY OR TOWN <i>Cumberland,</i>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <i>310 Harrison St.</i>					
14. FATHER'S NAME First <i>Thomas</i> Middle <i>--</i> Last <i>Poole</i>			15. MOTHER'S MAIDEN NAME First <i>Elizabeth</i> Middle <i>--</i> Last <i>Trezise</i>														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <i>no</i> , or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <i>None</i>			17. INFORMANT Address <i>Mt. Thomas Geary, 200 Glenn St. Frostburg, Md.</i>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Adenocarcinoma Thyroid</i> <i>193X</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>metastasis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arteriosclerotic Cardio-vascular disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 mos.</i>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>194X</i>																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from <i>April 18, 1968</i> to <i>May 4, 1968</i> , that (I) (we) last saw the deceased alive on <i>May 4, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <i>John B. Davis M.D.</i>			DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/>			MED. DIRECTOR <input type="checkbox"/>			STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <i>5/4/68</i>		
22d. PHYSICIAN'S NAME (Type) <i>John B. Davis, M. D.</i>			22e. ADDRESS <i>2 Broadway, Frostburg, Md. 21532</i>														
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE <i>5/6/68</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Frostburg Memorial Park</i>			23d. LOCATION (City or Town) (County) (State) <i>Frostburg, Allegany Md.</i>								
24. FUNERAL DIRECTOR <i>H. Wayne George</i>			ADDRESS <i>Cumberland, Maryland</i>			25a. REC'D BY REGISTRAR DATE <i>MAY 7 1968</i>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>								

00230

CERTIFICATE OF CLAY

00230



OFFICE OF THE
SHERIFF
CLAY COUNTY
MISSISSIPPI

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div>06394</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>06400</div>																
1. DECEASED-NAME (Type or print)			First JAMES			Middle E.			Last CROSS			2a. DATE OF DEATH Month MAY Day 5 Year 1968			2b. HOUR 7:00 AM	
3. SEX MALE			4. RACE WHITE			5. DATE OF BIRTH 7-16-1910			6. AGE (In years last birthday) 57 YRS.			IF UNDER 1 YEAR MONTHS 5 DAYS 19		IF UNDER 24 HRS. HOURS 17 MIN. 00		
7a. BIRTHPLACE (State or foreign country) CUMBERLAND, MD.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH ALLEGANY Md.							
10. CITY OR TOWN OF DEATH CUMBERLAND,			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Machinist			12b. KIND OF BUSINESS OR INDUSTRY R.R.							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE W. VA.			13b. COUNTY MINERAL			13c. CITY OR TOWN WILEY FORD			13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			13e. STREET AND NUMBER				
14. FATHER'S NAME First JAMES Middle T. Last CROSS						15. MOTHER'S MAIDEN NAME First FANNIE Middle PRICE Last PRICE										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes			16b. SOCIAL SECURITY NO. 705-09-9504			17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>metastatic Carcinoma</u> 1621 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of lung</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 weeks</u> <u>6 mos</u>																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 163x																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)										
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State										
22a. I certify that (I) (this hospital) attended the deceased from <u>23 April, 1968</u> , to <u>5 May, 1968</u> , that (I) (we) last saw the deceased alive on <u>5 May, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE <u>James B. Stegmaier M.D.</u>						22c. DATE SIGNED <u>6 May 68</u>			22d. PHYSICIAN'S NAME (Type) DR. STEGMAIER							
22e. ADDRESS 122 SO. CENTRE ST., CUMBERLAND, MD.						22f. ADDRESS										
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE July 7, 1968			23c. NAME OF CEMETERY OR CREMATORY Restlawn Memorial Park			23d. LOCATION (City or Town) (County) (State) Cumberland, Alleg. Md.							
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.						25a. REC'D BY REGISTRAR DATE MAY 10 1968			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							

09420

90 : 2251

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

06395

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06401

1. DECEASED-NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF DEATH			Month	Day	Year	2b. HOUR	
OLIVE GRACE CROSS						May, 22, 1968			19			11:45 A.M.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS	2c. DATE PRONOUNCED DEAD			Month	Day	Year	2d. HOUR	
FEMALE	WHITE	JUNE 8, 1904	63 YRS.			May 22, 1968			19			11:50 A.M.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH			Md.				
CUMBERLAND MD.		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		ALLEGANY							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY				
CUMBERLAND			216 PARK STREET			HOUSE WIFE							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER	
MARYLAND			ALLEGANY			CUMBERLAND						216 PARK STREET	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last		
ARTHUR J. WILSON						NANCY						NORTH	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS							
NO			211-07-1028D			JAMES BUFORD CROSS 216 PARK ST. CUMBERLAND							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. CORONARY SCLEROSIS (b) DUE TO, OR AS A CONSEQUENCE OF (c)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SUDDEN ---		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o) 4201													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 1B.)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE			Benedict Skitarelis			M.D.			22b. DATE SIGNED				
EXAMINER'S NAME (Type)			BENEDICT SKITARELIC, M.D.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			MAY 22, 1968				
						ADDRESS (Street, city, town, or county)			Cumberland, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)					
BURIAL			25 MAY 68		HILLCREST BURIAL PARK			RFD# 2 CUMBERLAND ALLEGANY MARYLAND					
24. FUNERAL DIRECTOR			H. LEE SILCOX 404 DECATUR ST CUMBERLAND MD.			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
						DATE			MAY 27 1968 Charles Judge				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month		2b. HOUR
HOWARD				CROWE	MAY 24 1968		12:15
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
MALE	WHITE		MARCH 13/1879		89		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
GARRETT CO.		USA				ALLEGANY Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital during most of working life, even if retired.)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
CUMBERLAND		MEMORIAL HOSPITAL		Farmer		Own Farm	
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSURE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
MARYLAND		ALLEGANY CO.		LONAC., MD.		RT. #1, LONACONING, MD.	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		
JOHN				CROWE	JANE Crowe		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address			
no		219-54-1887		MEMORIAL HOSPITAL, CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SENILITY</u>							
1723 DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
(b) <u>CARDIAC DECOMPENSATION</u>							
DUE TO, OR AS A CONSEQUENCE OF							
(c) <u>MALIGNANCY - RIGHT FACIAL</u>							2 YRS.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
1913							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
NONE				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
		None May Day 19					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from MAY 6, 1968, to MAY 24, 1968, that (I) (we) last saw the deceased alive on MAY 23, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE <u>Dr. Cawley</u>				DEGREE		22c. DATE SIGNED	
						MAY 24/68	
22d. PHYSICIAN'S NAME (Type) DR. CAWLEY				22e. ADDRESS			
				MEMORIAL HOSP., CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial		5/27/68		Crowe Cemetery		Raurel Lonaconing G. Md.	
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
George Eichhorn				DATE MAY 28 1968		<u>Charles Judge</u>	

04382
05403

HOWARD CROWE MAY 27 1958 12:12

MALE WHITE MARCH 12 1957 83

GARRITTO, USA X ALLEGANY

MEMORIAL HOSPITAL

MARYLAND AND VIRGINIA CO., MD. X

JOHN CROWE JANE CROWE

515-21-1-27 MEMORIAL HOSPITAL, CUMBERLAND, MD.

201-2-1-27

Expire Date: 12/31/58

Warranted Right to Life 2 yrs

None

None

None

May 23 1958

CR. CANCEY

MEMORIAL HOSP., CUMBERLAND, MD.

May 24 1958

Warranted Right to Life 2 yrs

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
CERTIFICATE OF DEATH																	
1. DECEASED-NAME (Type or print)			First Benjamin			Middle Franklin			Last Davis			2a. DATE OF DEATH May 24 Day 1968			2b. HOUR P 11:05 AM		
3. SEX Male			4. RACE White			5. DATE OF BIRTH April 24, 1882			6. AGE (In years last birthday) 86 YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) W. Va.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Allegany Md.								
10. CITY OR TOWN OF DEATH Cumberland			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) D.O.A. Memorial			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired Miner			12b. KIND OF BUSINESS OR INDUSTRY Coal								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Allegany			13c. CITY OR TOWN Cumberland			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 22 Potomac St.					
14. FATHER'S NAME First Middle Last Thomas Davis			15. MOTHER'S MAIDEN NAME First Middle Last Eliza Bray														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No			16b. SOCIAL SECURITY NO. (If yes give war or dates of service)			17. INFORMANT Mrs. Bessie Keller, Cumberland, Md. Sister											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intestinal Hemorrhage severe</u> <u>5320</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>5470</u> (b) <u>Duodenal ulcer, recurrent</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>? 10 years</u>																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>A.S. Endocrine disease with gen. arteriosclerosis</u>																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from <u>24 May, 1968</u> to <u>24 May, 1968</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <u>W. A. Van Ormer</u>			DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED May 26, 1968											
22d. PHYSICIAN'S NAME (Type) Dr. W. A. Van Ormer			22e. ADDRESS 122 S. Centre St., Cumberland, Md.														
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE May 27, 1968			23c. NAME OF CEMETERY OR CREMATORY Nethken Hill Cemetery			23d. LOCATION (City or Town) (County) (State) Near Elk Garden, W. Va.								
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.			ADDRESS			25a. REC'D BY REGISTRAR DATE MAY 29 1968			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>								

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

<div>06393</div> <div>JEANETTE</div> <div>06404</div>											
<div>2</div> <div>1</div> <div>06393</div> <div>06404</div>											
<div>1. DECEASED-NAME (Type or print)</div> <div>JEANETTE</div> <div>2. DATE OF DEATH</div> <div>MAY</div> <div>Month 23</div> <div>Day 1968</div> <div>Year</div> <div>2b. HOUR</div> <div>6:30</div> <div>PM</div>											
<div>3. SEX</div> <div>FE</div> <div>4. RACE</div> <div>WHITE</div> <div>5. DATE OF BIRTH</div> <div>JULY 6</div> <div>1894</div> <div>6. AGE (In years last birthday)</div> <div>73</div> <div>YRS.</div> <div>IF UNDER 1 YEAR</div> <div>MONTHS</div> <div>DAYS</div> <div>IF UNDER 24 HRS.</div> <div>HOURS</div> <div>MIN.</div>											
<div>7a. BIRTHPLACE (State or foreign country)</div> <div>MARYLAND</div> <div>7b. CITIZEN OF WHAT COUNTRY?</div> <div>U.S.</div> <div>8. MARRIED</div> <div><input checked="" type="checkbox"/> NEVER MARRIED</div> <div><input type="checkbox"/> WIDOWED</div> <div><input type="checkbox"/> DIVORCED</div> <div>9. COUNTY OF DEATH</div> <div>ALLEGANY</div> <div>MD.</div>											
<div>10. CITY OR TOWN OF DEATH</div> <div>CUMBERLAND</div> <div>11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)</div> <div>CUMB. NURSING HOME</div> <div>12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)</div> <div>HOUSEWIFE</div> <div>12b. KIND OF BUSINESS OR INDUSTRY</div> <div>Own Home</div>											
<div>13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE</div> <div>MD.</div> <div>13b. COUNTY</div> <div>ALLEGANY</div> <div>13c. CITY OR TOWN</div> <div>OLD TOWN</div> <div>13d. INSIDE CITY LIMITS?</div> <div>YES</div> <div><input checked="" type="checkbox"/> NO</div> <div>13e. STREET AND NUMBER</div> <div>MAIN STREET</div>											
<div>14. FATHER'S NAME</div> <div>Ashford</div> <div>15. MOTHER'S MAIDEN NAME</div> <div>Mary E. Wilson</div> <div>16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)</div> <div>Yes</div> <div>16b. SOCIAL SECURITY NO.</div> <div></div> <div>17. INFORMANT</div> <div>Maria Dwyer</div> <div>Address</div> <div>RD 1 Old Lion Md.</div>											
<div>18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c).)</div> <div>PART 1. DEATH WAS CAUSED BY:</div> <div>IMMEDIATE CAUSE (a)</div> <div>Carcinoma of Ovary</div> <div>1830</div> <div>DUE TO, OR AS A CONSEQUENCE OF</div> <div>(b)</div> <div>Metastasis to Lung</div> <div>DUE TO, OR AS A CONSEQUENCE OF</div> <div>(c)</div> <div>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:</div> <div>3 yrs</div> <div>2 yrs</div>											
<div>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</div> <div>1750</div>											
<div>19a. DATE OF OPERATION</div> <div>19b. CONDITION FOR WHICH OPERATION WAS PERFORMED</div> <div>20a. AUTOPSY?</div> <div>YES</div> <div><input type="checkbox"/> NO</div> <div><input checked="" type="checkbox"/></div> <div>20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</div>											
<div>21a. ACCIDENT WAS UNDERLYING</div> <div><input type="checkbox"/> OR CONTRIBUTING</div> <div><input type="checkbox"/> CAUSE OF DEATH</div> <div>(If either, notify medical examiner)</div> <div>21b. TIME OF INJURY</div> <div>HOUR A.M.</div> <div>Month</div> <div>Day</div> <div>Year</div> <div>P.M.</div> <div>19</div> <div>21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)</div>											
<div>21d. INJURY OCCURRED</div> <div>While</div> <div><input type="checkbox"/> Not while</div> <div>at work</div> <div>21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)</div> <div>21f. LOCATION</div> <div>Street or R.F.D. No.</div> <div>City or Town</div> <div>County</div> <div>State</div>											
<div>22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.</div>											
<div>22b. SIGNATURE</div> <div>W Royce Hodges, M.D.</div> <div>DEGREE</div> <div>ATTENDING PHYS.</div> <div><input checked="" type="checkbox"/></div> <div>MED. DIRECTOR</div> <div><input type="checkbox"/></div> <div>STAFF PHYS.</div> <div><input type="checkbox"/></div> <div>22c. DATE SIGNED</div> <div>5/24, 1968</div>											
<div>22d. PHYSICIAN'S NAME (Type)</div> <div>Dr. Wm. Royce Hodges, M.D.</div> <div>22e. ADDRESS</div> <div>122 S. Centre St., Cumberland, Md.</div>											
<div>23a. BURIAL, CREMATION, REMOVAL (Specify)</div> <div>Burial</div> <div>23b. DATE</div> <div>May 26, 1968</div> <div>23c. NAME OF CEMETERY OR CREMATORY</div> <div>Mt. Tabor Cemetery</div> <div>23d. LOCATION (City or Town) (County) (State)</div> <div>Near Oldtown, Md. Allegany C.</div>											
<div>24. FUNERAL DIRECTOR</div> <div>SCARPELLI</div> <div>ADDRESS</div> <div>CUMB.</div> <div>108 VIRGINIA AVE. MD.</div> <div>25a. REC'D BY REGISTRAR</div> <div>DATE</div> <div>May 29 1968</div> <div>25b. REGISTRAR'S SIGNATURE</div> <div>James Judge</div>											

MEDICAL CERTIFICATION

02204

RECEIVED BY MAIL

00000

W. R. ...
2-2-1-02

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form RW-100. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

06399

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06405

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			Month	Day	Year	2b. HOUR		
Luka Davis						May 9, 1968			6:40			P M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c. DATE PRONOUNCED DEAD			Month	Day	Year	2d. HOUR
Male	White	Oct. 5, 1912	55 YRS.					May 9, 1968			6:40	P M		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH					
Spring Gap Md.			U.S.A.						Allegany Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY					
Cumberland Md.			Memorial Hosp.			Costodian,								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER		
Maryland			Allegany			Cumberland			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			R.F.D. #4 Cumberland Md.		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME											
Charles Davis			Loretta Stallings											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS								
Yes			WW II			Mark Davis R.F.D. #4 Box 265 Cumberland Md.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4109</u> <u>Coronary Occlusion</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Coronary Sclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>---</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS <u>4201</u> CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.			City or Town			County State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE <u>Benedict Skitaralic</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED					
EXAMINER'S NAME (Type) <u>BENEDICT SKITARELIC, M.D.</u>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county) <u>Cumberland, Maryland</u>								
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)					
Burial			5/12/68			Davis Family Cem.			Spring Gap, Md. (allegany)					
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
Louis Stein Inc.			Cumberland Md.			DATE MAY 13 1968			Charles Judge					

20286

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



06400

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06406

1. DECEASED-NAME (Type or print)			First	Middle	Lost	2a. DATE OF DEATH			Month	Day	Year	AM	2b. HOUR		
BABY			GIRL			DE HAVEN			MAY	13	1968		XXXXXX E-4P		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.				
FEMALE		WHITE		05-12-68			YRS.		MONTHS	DAYS	HOURS	MIN.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH								
U.S.A. MARYLAND		U.S.A.					ALLEGANY Md.								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY						
CUMBERLAND			SACRED HEART HOSPITAL												
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER			
MD.			ALLEGANY			CUMBERLAND						RT#2, BALT. PIKE,			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME												
First Middle Lost			First Middle Lost												
H. GENE DE HAVEN			(HOOK) HELEN CHRISTINA DE HAVEN												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT									
						HOSPITAL RECORD									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) <u>Respiratory Failure</u>															
776.2 DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.															
(b) <u>Pneumatury</u>															
DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
7735															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)									
			HOUR A.M. Month Day Year P.M. 19												
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost the deceased on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE												22c. DATE SIGNED			
<u>Robert J. Brodell M.D.</u>															
22d. PHYSICIAN'S NAME (Type)												22e. ADDRESS			
DR. ROBERT BRODELL												500 GREENE ST., CUMB., MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)						
Burial			5/16/68			County Cem			Cumberland Md						
24. FUNERAL DIRECTOR												25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
<u>Louis Stein Inc Cumb. Md.</u>												DATE MAY 20 1968		<u>Charles Judge</u>	

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DATE 10-10-68 TIME 10:00 AM
BY J. H. HARRIS
TO J. H. HARRIS
SUBJECT: [illegible]

RE: [illegible]
[illegible]
[illegible]

U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C. 20535

TO: DIRECTOR, FBI
FROM: SAC, [illegible]
SUBJECT: [illegible]

RE: [illegible]
[illegible]
[illegible]

U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C. 20535

TO: DIRECTOR, FBI
FROM: SAC, [illegible]
SUBJECT: [illegible]

RE: [illegible]
[illegible]
[illegible]

U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C. 20535

TO: DIRECTOR, FBI
FROM: SAC, [illegible]
SUBJECT: [illegible]

RE: [illegible]
[illegible]
[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) GEORGE AMBROSE DIEHL			2a. DATE OF DEATH Month May Day 22 Year 68			2b. HOUR 1:30aM									
3. SEX Male		4. RACE White		5. DATE OF BIRTH May 2, 1886		6. AGE (In years last birthday) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS. HOURS MIN					
7a. BIRTHPLACE (State or foreign country) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Allegany Md.									
10. CITY OR TOWN OF DEATH Cumberland			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 808 Gephart Drive			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Construction Supply			12b. KIND OF BUSINESS OR INDUSTRY Cement						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 808 Gephart Drive						
14. FATHER'S NAME First Taylor Middle Diehl Last			15. MOTHER'S MAIDEN NAME First Martha Middle Last												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) Unk.			16b. SOCIAL SECURITY NO.		17. INFORMANT Address Anna M. Diehl 808 Gephart Dr. Cumb., Md.										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Paralysis Agitans 342x DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 350x (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 yrs.															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Generalized Debility, Upper Resp. Infection															
19a. DATE OF OPERATION non		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from 9/19/57 , 19 57 , to 3/14 , 19 68 , that (I) (we) last saw the deceased alive on 3/14/68 , 19 68 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE Thomas F. Lusby										DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 5/23/68	
22d. PHYSICIAN'S NAME (Type) Thomas F. Lusby					22e. ADDRESS 932 National H'wy. LaVale, Md.										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/24/68		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park			23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.								
24. FUNERAL DIRECTOR Philip B. Wendt 121 Memorial Ave., Cumb., Md.					ADDRESS		25a. REC'D BY REGISTRAR DATE MAY 27 1968		25b. REGISTRAR'S SIGNATURE J. Charles Young						

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RECEIVED

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Handwritten notes and stamps at the top of the page, including a date stamp "MAY 1968" and various illegible markings.

Handwritten signature or name, possibly "B. J. ..."

Handwritten text, possibly "B. J. ..."

Handwritten notes and stamps at the bottom of the page, including a date stamp "MAY 1968" and various illegible markings.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

06402				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				06408			
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR				
ALLEN				GARDNER	May 19 th Day 1968		M				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Male		White		10/12/1905		62 YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
MD.		USA.				Allegany				Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Frostburg		Miners Hospital		Laborer							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
MD.		Allegany		Lonaconing				Allegany St.			
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last		
Edward				Gardner	Martha				Tenant		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address					
No				Mrs. Ada Gardner		Lonaconing, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Ischemia										3 days	
4109 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Insufficiency										?	
(c) Generalized Arteriosclerosis										years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
4201											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		County		State
22a. I certify that (I) (this hospital) attended the deceased from 1960, to May 19, 1968, that (I) (we) last saw the deceased alive on May 19, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE L. R. MILES, JR., M.D.										22c. DATE SIGNED 5-20	
22d. PHYSICIAN'S NAME (Type) L. R. MILES, JR., M.D.										22e. ADDRESS LONA CONING MD, 21539	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		5/21/1968		Laurel Hill Cemetery		Moscow, Allegany, MD.					
24. FUNERAL DIRECTOR George Eichhorn						25a. REGD BY REGISTRAR DATE MAY 21 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			
Lonaconing, Md.											

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ALLAN GARDNER MAY 19 1968

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06403										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										06409									
Items #4 & 6, film G401 6/7/68										CERTIFICATE OF DEATH																			
1. DECEASED-NAME (Type or print) Naomi Gates					First Middle Last					2a. DATE OF DEATH Month 5 Day 26 Year 68					2b. HOUR 3:30 PM														
3. SEX F					4. RACE White American					5. DATE OF BIRTH Sept. 5, 1887					6. AGE (In years last birthday) 79 YRS.					IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.									
7a. BIRTHPLACE (State or foreign country) Maryland					7b. CITIZEN OF WHAT COUNTRY? America					B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH Allegany Md.														
10. CITY OR TOWN OF DEATH Cumberland					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Cumberland Nursing Home					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife					12b. KIND OF BUSINESS OR INDUSTRY														
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland					13b. COUNTY Allegany					13c. CITY OR TOWN LaVale					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					13e. STREET AND NUMBER 17 N. Woodlawn Ave.									
14. FATHER'S NAME First Middle Last Denton -- Bucy					15. MOTHER'S MAIDEN NAME First Middle Last Mary --- Huff																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No					16b. SOCIAL SECURITY NO.					17. INFORMANT Mrs. Mary Hosselrode LaVale, Md.					17a. Address 17 N. Woodlawn Ave.														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 188X Cancer of the bladder DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1810																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from 3-1-68, 1968, to 5-26-68, 1968, that (I) (we) last saw the deceased alive on 5-19-68, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE L. Hosselrode MD										DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED 5-28-68														
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS																								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE May 29, 1968					23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park					23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.														
24. FUNERAL DIRECTOR Philip B. Wendt 121 Memorial Ave., Cumb., Md.					ADDRESS					25a. REC'D BY REGISTRAR DATE MAY 31 1968					25b. REGISTRAR'S SIGNATURE Charles Judge														

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MD404
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH
06410

1. DECEASED-NAME (Type or print)		First LEANNA		Middle R.		Last GOLDEN		2a. DATE OF DEATH Month 5 Day 26 Year 68			2b. HON. 7:29	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 12-12-98			6. AGE (In years last birthday) 69 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md.						
10. CITY OR TOWN OF DEATH CUMBERLAND			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.			13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 618 ELM STREET			
14. FATHER'S NAME First JAMES			Middle SPRIGG			Last SUSAN			15. MOTHER'S MAIDEN NAME First MOSES			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no			16b. SOCIAL SECURITY NO. 110			17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD. Address						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Dissected Malignant 2509 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Aneurysm DUE TO, OR AS A CONSEQUENCE OF (c) 1 week										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 260x		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State		
22a. I certify that (I) (this hospital) attended the deceased from 5/19/68 , to 5/26/68 , that (I) (we) last saw the deceased alive on 5/26/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Dr. Blane Schindler						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 5/27/68				
22d. PHYSICIAN'S NAME (Type) DR. BLANE SCHINDLER						22e. ADDRESS 43 GREENE ST., CUMBERLAND, MD.						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE May 29, 1968		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City or Town) Cumberland, Allegany, Md.		(County)		(State)		
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.						25a. REC'D BY REGISTRAR DATE JUN 3 1968		25b. REGISTRAR'S SIGNATURE [Signature]				

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CENTRAL DE WASH

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ORDER

LEAHNA

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ALLIANCE

U. S. A.

MARYLAND

MEMORIAL HOSPITAL

CUMBERLAND

815 ELM STREET

CUMBERLAND, MD

MD

EDGES

SUGAR

STRIKE

JAMES

MEMORIAL HOSPITAL - CUMBERLAND, MD

DR. BLANE SCHINDLER

23 GREENE ST., CUMBERLAND, MD.

004 3 300

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1, 2 and 3 and 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (1)
30M REV. 1/58

06405				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				06411			
Item 136, c, Film 401 6/21/68 km				CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print)		First Ida		Middle C.		Last Grady		2a. DATE OF DEATH May Month 21 Day 1968 Year		2b. HOUR 9:20 M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH October 12, 1879		6. AGE (In years last birthday) 88 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Allegany Md.					
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Sylvan Retreat		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER C Street			
14. FATHER'S NAME First Isaac		Middle Fishell		Last Sarah		15. MOTHER'S MAIDEN NAME First Sarah		Middle Palmer		Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Anna Cutter		Address Klondike, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) generalized arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 4201										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from April 15, 1967, to May 21, 1968, that (I) (we) last saw the deceased alive on May 21, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE George M. Simons		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) George M. Simons M.D.		22e. ADDRESS Memorial Hospital, Cumberland, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/24/68		23c. NAME OF CEMETERY OR CREMATORY Zion Memorial Park		23d. LOCATION (City or Town) Cumberland		(County) Alleg		(State) Maryland	
24. FUNERAL DIRECTOR H. Lee Silcox		ADDRESS Cumberland, Maryland 21502		25a. REC'D BY REGISTRAR DATE MAY 27 1968		25b. REGISTRAR'S SIGNATURE Charles Judge					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06406		08412	
1. DECEASED-NAME (Type or print) CARRIE GREEN		2a. DATE OF DEATH Month MAY Day 22 Year 1968	
3. SEX Female	4. RACE White	5. DATE OF BIRTH Sept. 25, 1890	6. AGE (In years last birthday) 77 YRS.
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
9. COUNTY OF DEATH Allegany		10. CITY OR TOWN OF DEATH Frostburg	
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Miners Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Allegany	
14. FATHER'S NAME First Middle Last JAMES MOORE		15. MOTHER'S MAIDEN NAME First Middle Last MARY ANN JONES	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No		16b. SOCIAL SECURITY NO. 4109	
17. INFORMANT WILLIAM GREEN, Lonaconing, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Ischemia (Husband) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 4201 (b) Coronary Insufficiency DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Atherosclerosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days 3	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Acute Congestive Failure - marked Obesity			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town County State
22a. I certify that (I) (this hospital) attended the deceased from 1965 , to May 22 1968 , that (I) (we) lost saw the deceased alive on May 21 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE L.R. Miles, Jr.		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 5-23-68
22d. PHYSICIAN'S NAME (Type) L.R. MILES, JR., M.D.		22e. ADDRESS LONA CONING MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 5/25/1968	23c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery	23d. LOCATION (City or Town) (County) (State) Moscow, Allegany, Md.
24. FUNERAL DIRECTOR George Eichhorn, Lonaconing, Maryland		25a. REC'D BY REGISTRAR MAY 27 1968	25b. REGISTRAR'S SIGNATURE Charles Judge

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OFFICE OF THE

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June 15, 1940

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VR A 13-64
30M REV. 11-68

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
CLARA			BELL			HELFRICH		MAY 17 1968 7:50 PM		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
FEMALE		WHITE		6-16-1888			79 YRS.			
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
CUMB. MD.			USA				ALLEGANY COUNTY Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
CUMBERLAND, MD.			MEMORIAL HOSPITAL			HWFE.				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND			ALLEGANY		CUMBERLAND				727 SYLVAN AVENUE	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
WILLIAM BROPHY			MARY ELLA DANNER							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
NO			211-05-7230D		MEMORIAL HOSPITAL, CUMBERLAND, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <i>Myocarditis & Decompensation</i>									6 min	
174X DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										
(b) <i>Arteriosclerosis</i>									5 yrs	
DUE TO, OR AS A CONSEQUENCE OF										
(c) <i>Squamous Epithelioma Left Breast</i>									8 yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
170X										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from June 19 1966 to May 17, 1968, that (I) (we) last saw the deceased alive on May 17, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE		22c. DATE SIGNED								
clay E. Durrett		5/18/68								
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS								
DR. CLAY E. DURRETT		236 VIRGINIA AVE., CUMBERLAND, MD.								
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		5/21/68		S.S. Peter & Paul Cemetery		Cumberland Alleg Maryland				
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE						
H. Lee Silcox		MAY 21 1968		Charles Judge						
Cumberland, Maryland 21502										

004130

00413

CLARA
 WHITE
 8-10-1988
 ALLEGANY COUNTY
 ALLEGANY
 CUMBERLAND, MD.
 707 SYLVIA AVENUE
 BROOKLYN
 CUMBERLAND, MD.
 707 SYLVIA AVENUE

*Specimens of the following are being
 submitted for analysis
 Microscopic & Chemically*

Clay E. Durrett
March 17 to June 12 1988
2/15/88
 DR. CLAY E. DURRETT
 230 VIRGINIA AVE., CUMBERLAND, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First ORLANDA Middle EARL Last HENSEL			2a. DATE OF DEATH MAY Month 24 Day 1968		2b. HOUR 2:00 PM
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH AUGUST 18, 1895		6. AGE (In years last birthday) 72 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) CUMBERLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH ALLEGANY Md.		
10. CITY OR TOWN OF DEATH CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life. If retired, state) RETIRED BLACKSMITH OF B&O RAILROAD	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND	13b. COUNTY ALLEGANY	13c. CITY OR TOWN RFD1 CUMBERLAND	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER RFD/1 GREENPOINT CUMBERLAND	
14. FATHER'S NAME First HENRY Middle CHARLES Last HENSEL		15. MOTHER'S MAIDEN NAME First ALICE Middle C. Last BELL			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) YES WWI		16b. SOCIAL SECURITY NO. 705-05-4726	17. INFORMANT Address ELSIE H. HENSEL RFD# 1 GREENPOINT, CUMBERLAND		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u> 4549 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Saphenous varicocoeles</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hours					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4621 (1) <u>Hypertensive cardiovascular disease</u> (2) <u>adhesive pericarditis</u>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 5-24, 1968, to 5-24, 1968, that (I) (we) last saw the deceased alive on 5-24 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE V. P. Dross MD		DEGREE	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 5-25-68	
22d. PHYSICIAN'S NAME (Type) V. P. DROSS		22e. ADDRESS 456 NORTH CENTRE STREET CUMBERLAND MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 27 MAY 68	23c. NAME OF CEMETERY OR CREMATORY REST LAWN MEMORIAL PARK	23d. LOCATION (City or Town) (County) (State) LAVALE ALLEGANY MARYLAND		
24. FUNERAL DIRECTOR H. LEE SILCOX 404 DECATUR ST CUMBERLAND MD		ADDRESS	25a. REC'D BY REGISTRAR MAY 27 1968	25b. REGISTRAR'S SIGNATURE Charles Judge	

41480

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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<div style="display: flex; justify-content: space-between;"> 06409 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 06415 </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>																						
1. DECEASED-NAME (Type or print)			First Jacob			Middle NMI			Last Hout			2a. DATE OF DEATH Month May			Day 23			Year 1968			2b. HOUR 8:25 PM	
3. SEX Male			4. RACE White			5. DATE OF BIRTH October 17, 1902			6. AGE (In years last birthday) 65 YRS.			IF UNDER 1 YEAR MONTHS 0			DAYS 0			IF UNDER 24 HRS. HOURS 0			MIN. 0	
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? U S A			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Allegany Md.													
10. CITY OR TOWN OF DEATH Frostburg			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Miners Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Highway Maintenance Supr. Road Comm.			12b. KIND OF BUSINESS OR INDUSTRY 12. Stat													
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Allegany			13c. CITY OR TOWN Frostburg			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 68 Linden Street										
14. FATHER'S NAME First Charles			Middle J.			Last Hout, Sr.			15. MOTHER'S MAIDEN NAME First Emily			Middle Handel			Last Handel							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) No			16b. SOCIAL SECURITY NO.			17. INFORMANT Address Mrs. Ruth R. Hout, 68 Linden St., Frostburg Md																
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Posterior Coronary occlusion 410.0 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive C.V.D. DUE TO, OR AS A CONSEQUENCE OF (c) Prev. History of Coronary APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr - 5 yrs -																						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201																						
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State																
22a. I certify that (I) (this hospital) attended the deceased from May , 19 66 , to May 23 , 19 66 , that (I) (we) last saw the deceased alive on 5/23 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																						
22b. SIGNATURE John B. Davis, M.D. DEGREE M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. DATE SIGNED 5/25/68																						
22d. PHYSICIAN'S NAME (Type) John B. Davis, M.D. 22e. ADDRESS Frostburg, Md.																						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE May 26, 1968			23c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery			23d. LOCATION (City or Town) (County) (State) Cumberland Alleg Md.													
24. FUNERAL DIRECTOR John J. Hafer, Jr.			ADDRESS 230 Balto Ave. Cumberland Md			25a. REC'D BY REGISTRAR MAY 28 1968			25b. REGISTRAR'S SIGNATURE Charles Judge													

00212

00212

2025 COLLECTOR SHEET

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06410		06416	
1. DECEASED-NAME (Type or print) Jessie		First Middle Last James	
2a. DATE OF DEATH May Month 28 Day 1968 Year		2b. HOUR a.m. or p.m. 11.30 M	
3. SEX Female	4. RACE White	5. DATE OF BIRTH Aug. 31, 1885	6. AGE (In years last birthday) 82 YRS.
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Allegany Md.
10. CITY OR TOWN OF DEATH Barton	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Rural	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) house wife	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Md.	13b. COUNTY Allegany	13c. CITY OR TOWN Barton	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME First Middle Last William Anderson		15. MOTHER'S MAIDEN NAME First Middle Last Minerva Miller	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (no, or unknown) no (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address Phyllis Dye-Barton, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-sclerotic disease DUE TO, OR AS A CONSEQUENCE OF (c) Cardiac Hypertrophy			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 4201 Possible Carcinoma of Stomach			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 5-19, 1968 , to 5-26, 1978 , that (I) (we) last saw the deceased alive on 5-22, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE H.C. Diehl M.D.		22c. DATE SIGNED 5/27/68	
22d. PHYSICIAN'S NAME (Type) H.C. Diehl		22e. ADDRESS Frostburg, Md.	
23a. BURIAL, CREMATION, (Specify) Burial	23b. DATE 5/29/68	23c. NAME OF CEMETERY OR CREMATORY Mt. View	23d. LOCATION (City or Town) (County) (State) Moscow Mills, Md
24. FUNERAL DIRECTOR E. J. Boal		25a. REC'D BY REGISTRAR DATE MAY 29 1968	25b. REGISTRAR'S SIGNATURE Charles Judge

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1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.

- 95 -

Dr. J. H. M. van der Velden

NOV 1991

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A75
30M REV. 1-58

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 06411 | | 06417 | |
| 1. DECEASED-NAME
(Type or print) First ADA Middle B. Last JENKINS | | 2a. DATE OF DEATH
Month MAY Day 20 Year 1968 | |
| 3. SEX
FEMALE | | 2b. HOUR
10:30P | |
| 4. RACE
WHITE | | 5. DATE OF BIRTH
FEBRUARY 9, 1907 | |
| 6. AGE (In years last birthday)
61 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
USA | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
ALEEGANY Md. | |
| 10. CITY OR TOWN OF DEATH
CUMBERLAND, MD. | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
SACRED HEART HOSP. | |
| 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND | | 13b. CITY OR TOWN
CUMBERLAND | |
| 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET AND NUMBER
27 MARION ST. | |
| 14. FATHER'S NAME First THOMAS Middle G. Last LEWIS | | 15. MOTHER'S MAIDEN NAME First WORKMAN Middle MARY Last MAUDE LEWIS | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or NO (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
215-20-6498 | |
| 17. INFORMANT
HOSPITAL RECORD | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE
3940
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) MITRAL STENOSIS + INSUFFICIENCY
DUE TO, OR AS A CONSEQUENCE OF
(c) RHEUMATIC HEART DISEASE
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
10 YRS
50 YRS | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
410X | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | |
| 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from JUNE , 19 60 , to 5-20 , 19 68 , that (I) (we) last saw the deceased alive on 5-20 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
Lm Glick MD | | 22c. DATE SIGNED
5-21-68 | |
| 22d. PHYSICIAN'S NAME (Type) L. MICHAEL Glick | | 22e. ADDRESS
126 N. SMALLWOOD ST. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
May 23, 1968 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Hillcrest Burial Park | | 23d. LOCATION (City or Town) (County) (State)
Cumberland, Md. Allegany | |
| 24. FUNERAL DIRECTOR
James P. Scarpelli, Cumberland, Md. | | 25a. REC'D BY REGISTRAR
DATE MAY 24 1968 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------|--|------------------------------------------|--|
| 1. DECEASED-NAME
(Type or print) Adam | | First W. | | Middle Johnson | | Last | | 2a. DATE OF DEATH
Month May Day 12 Year 1968 | | 2b. HOUR
10:50 | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
3/24/85 | | 6. AGE (In years
lost birthday)
83 | | IF UNDER 1 YEAR
MONTHS 83 DAYS YRS. | | IF UNDER 24 HRS.
HOURS 10 MIN. | |
| 7a. BIRTHPLACE (State or foreign
country) Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Allegany County Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Cumberland | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
Allegany County Infirmary | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
Laborer | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE Maryland | | 13b. COUNTY
Allegany | | 13c. CITY OR TOWN
Cumberland | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
Southern Hotel, City | | | |
| 14. FATHER'S NAME
First Joseph Middle R. Last Johnson | | 15. MOTHER'S MAIDEN NAME
First Marie Middle E. Last Clark | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
217 10 7591 | | 17. INFORMANT
Furnace St. ext. 8
Allegany County Infirmary P.O. Box 599 record | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute coronary thrombosis
4109
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) A.S.
DUE TO, OR AS A CONSEQUENCE OF
(c) Chr. A.S.H.D.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
few minutes
many years
many years | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
4201
COPD | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from April 10 , 19 68 , to May 12 , 19 68 , that (I) (we) last saw the deceased alive on May 11 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
John A. Topper M.D. | | 22c. DATE SIGNED
5-13-68 | | 22d. PHYSICIAN'S NAME (Type)
John A. Topper M.D. | | 22e. ADDRESS
Memorial Hospital
Cumberland, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE
MAY 15, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
GREENMOUNT CEMETERY | | 23d. LOCATION (City or Town) (County) (State)
CUMBERLAND, MD. | | | | | |
| 24. FUNERAL DIRECTOR
BYRON KIGHT | | 25a. REC'D BY REGISTRAR
DATE MAY 17 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | | | |

MEDICAL CERTIFICATION

5132

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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06412

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06419

| | | | | | | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------|------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------|-------------------------------------------------|-----------------------------------|
| 1. DECEASED-NAME
(Type or print) | | First
MARY | Middle
Helen | Last
KELLY | 2a. DATE OF DEATH
Month 5 Day 4 Year 68 | | 2b. HOUR
9:00 AM | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
2-19-92 | | 6. AGE (In years last birthday)
76 YRS. | | IF UNDER 1 YEAR
MONTHS
DAYS | IF UNDER 24 HRS.
HOURS
MIN. |
| 7a. BIRTHPLACE (State or foreign country)
WEST VIRGINIA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
ALLEGANY Md. | | | |
| 10. CITY OR TOWN OF DEATH
CUMBERLAND | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
MEMORIAL HOSPITAL | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MARYLAND | | 13b. COUNTY
ALLEGANY | | 13c. CITY OR TOWN
CUMBERLAND | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
RT. 6, BOX 338 | |
| 14. FATHER'S NAME First
HENRY | | Middle
GORMER | | Last
GENEVIEVE | | 15. MOTHER'S MAIDEN NAME First
GENEVIEVE | | Middle
BISEL | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown)
no | | (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
MEMORIAL HOSPITAL | | | Address
CUMBERLAND, MD. |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Pulmonary Edema
486X
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 490X
(b) Bilateral Pneumonia
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Hours
week | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Arteriosclerotic Cardiovascular Disease-Chronic Myocarditis | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> at work <input type="checkbox"/> at home | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1955 , 19____, to May , 19 68 , that (I) do last saw the deceased alive on May 4 , 19 68 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) do (did) not view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
 | | DEGREE
DR. G. O. HIMMELWRIGHT | | ATTENDING PHYS.
<input checked="" type="checkbox"/> | | MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
5-11-68 | |
| 22d. PHYSICIAN'S NAME (Type)
DR. G. O. HIMMELWRIGHT | | 22e. ADDRESS
CUMBERLAND, MD. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
REMOVED | | 23b. DATE
May 6, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Mary's Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Cumberland, Allegany, Md. | | | |
| 24. FUNERAL DIRECTOR
James F. Scarpelli, Cumberland, Md. | | | | 25a. REC'D BY REGISTRAR
DATE MAY 17 1968 | | 25b. REGISTRAR'S SIGNATURE
 | | | |

1911

DEPARTMENT OF HEALTH

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KELLY

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MEMORIAL HOSPITAL

MARYLAND

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MEMORIAL HOSPITAL

CUMBERLAND, MD.

CUMBERLAND, MD.

DR. G. O. HINCHWORTH

1911

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 1514
30M REV. 7-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06420

| | | | | | | | | | | | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------|--------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|--------------------------------|------|--------------------------------|--|--------------|--|
| 1. DECEASED-NAME
(Type or print) | | First | Middle | Lost | 2a. DATE OF DEATH | | 2b. HOUR | | | | | | |
| John | | E. | | Kesner | May 5th. 1968 | | M | | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years lost birth day) | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | | |
| Male | | White | | 3/10/1900 | | 68 YRS. | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | | | |
| MD. | | USA. | | | | Allegany Md. | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| Frostburg | | Miners Hospital | | Retired-Kelly Tire Co. | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | | | | |
| MD. | | Allegany | | Midland | | | | Paradise St. | | | | | |
| 14. FATHER'S NAME | | First | Middle | Lost | 15. MOTHER'S MAIDEN NAME | | First | Middle | Lost | | | | |
| Enoch Kesner | | | | | Jennie M. Moon | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | | | | | | |
| No | | | | Mary A. Kesner Midland, Md. | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Hypertensive C.V.D. decomposed</u> (WIFE) <u>3 weeks</u>
<u>4120</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
<u>443X</u> | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>April</u> , 19 <u>68</u> , to <u>May 5</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>5/3</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | 22d. PHYSICIAN'S NAME (Type) | | | | | | | | 22e. ADDRESS | |
| John B. Davis, M.D. | | 5/6/68 | | John B. Davis | | Frostburg, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) | | (State) | | | |
| Burial | | 5/8/1968 | | Memorial Park | | Frostburg, Md. | | | | | | | |
| 24. FUNERAL DIRECTOR | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | DATE | | | | | | | |
| George Eichhorn | | MAY 8 1968 | | John B. Davis | | | | | | | | | |

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

06415

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06421

| | | | | | | | | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|----------------------------------------------------------------------------------------------------------|------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|--------------------------------------------------------------------------------------------------------|------------------------------------------|-------------------------------------------------------------------------------------|----------------------|--------------------------------------------------------|---------------------|
| 1. DECEASED-NAME
(Type or Print) | | First
NAOMI | Middle
LULA | Last
KNOTTS | | 20. DATE KNOWN OF DEATH
<input checked="" type="checkbox"/> ESTI-
<input type="checkbox"/> MATED | | Month
May | Day
5 | Year
1968 | 2b. HOUR
6:15 PM |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
March 29, 1914 | | 6. AGE (In years last birthday)
54 YRS. | IF UNDER 1 YEAR
MONTHS
DAYS | IF UNDER 24 HRS
HOURS
MIN. | 2c. DATE PRONOUNCED DEAD
Month
May | | Day
5 | Year
1968 | 2d. HOUR
6:15 PM |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Allegany Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Rawlings | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Res. along U. S. Rt. 220 | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Domestic | | 12b. KIND OF BUSINESS OR INDUSTRY
Restaurant | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | 13b. COUNTY
Allegany | | 13c. CITY OR TOWN
Rawlings | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
Along U. S. Rt. 220 | | | |
| 14. FATHER'S NAME
John | | First
E. | Middle
Dicken | Last
Mae | | 15. MOTHER'S MAIDEN NAME
Mae | | First
-- | Middle
Winterberg | Last | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown)
NO | | (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
214-07-4327 | | 17. INFORMANT
ADDRESS
Mr. Leon R. Knotts Rawlings, Maryland | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4109 CORONARY OCCLUSION
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
(b) CORONARY THROMBOSIS
DUE TO, OR AS A CONSEQUENCE OF
(c) -----
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
4201 | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
SUDDEN | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M.
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE
Benedict Skitarelic | | EXAMINER'S NAME (Type)
Benedict Skitarelic, M. D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
May 5, 1968 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
5/8/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Hillcrest Burial Park | | 23d. LOCATION (City or Town)
Cumberland | | (County)
Allegany | | (State)
Md. | |
| 24. FUNERAL DIRECTOR
H. Wayne George | | | | ADDRESS
Cumberland, Md. | | 25a. REC'D BY REGISTRAR
DATE MAY 9 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

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12520

826-50-412

RECEIVED

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 912. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, prior to burial, cremation, or removal, and in any event within 72 hours after death.

06416

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06422

| | | | | | | | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|------------------------------------------------------------------------------|-----------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|-------------------------------------------------------------------------------------|-------------------------------------------|----------------------------|------|---------------------------------------------------------------|
| 1. DECEASED-NAME
(Type or Print) | | First | Middle | Last | 2a. DATE KNOWN OF DEATH | | <input checked="" type="checkbox"/> Month | Day | Year | 2b. HOUR |
| EVA | | LOUISE | LANCASTER | MAY 12, 1968 | | 4:50 | | | M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | IF UNDER 1 YEAR
MONTHS | IF UNDER 24 HRS.
HOURS | MIN | 2c. DATE PRONOUNCED DEAD | | 2d. HOUR |
| FEMALE | WHITE | SEPT. 28, 1920 | | 47 YRS. | | | | MAY 12, 1968 | | 4:50A M |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | Md. | | |
| CUMBERLAND | | USA | | | | ALLEGANY | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during last working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| CUMBERLAND | | MEMORIAL HOSPITAL-DOA | | HOUSEWIFE | | OWN HOME | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | | |
| MD. | | ALLEGANY | | CUMBERLAND | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 219 HUMBIRD ST. | | |
| 14. FATHER'S NAME | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | First | Middle | Last | |
| CARL | | B. | MONGOLD | | ELSIE TWIGG | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | Husband | | |
| NO | | | | MR. JOHN H. LANCASTER | | CUMBERLAND, MD. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CORONARY OCCLUSION
410.9 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) CORONARY SCLEROSIS
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
SUDDEN
--- |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4201 | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M.
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | |
| ACTUAL SIGNATURE | | Benedict Skitarelic | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22b. DATE SIGNED | | |
| EXAMINER'S NAME (Type) | | BENEDICT SKITARELIC, M.D. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | MAY 12, 1968 | | |
| | | | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | CUMBERLAND, MARYLAND | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) | | (State) |
| BURIAL | | MAY 15, 1968 | | DAVIS MEMORIAL CEMETERY | | CUMBERLAND, ALLEGANY, MD. | | | | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| JAMES F. SCARPELLI, CUMBERLAND, MD. | | | | | | MAY 15 1968 | | Charles Judge | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 415 (1)
30M REV. 7/68

MD. STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|
| 1. DECEASED-NAME (Type or print)
JOSEPH WILFRED LANCASTER | | | 2a. DATE OF DEATH
Month MAY Day 10 Year 1968 | | | 2b. HOUR
7:28 AM | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
SEPT. 17, 1880 | | 6. AGE (In years last birthday)
87 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
ECKHART, MD. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
ALLEGANY Md. | |
| 10. CITY OR TOWN OF DEATH
FROSTBURG, MD. | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
MINERS HOSPITAL | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
MINER | | 12b. KIND OF BUSINESS OR INDUSTRY
COAL | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MARYLAND | | 13b. COUNTY
ALLEGANY | | 13c. CITY OR TOWN
FROSTBURG | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME First Middle Last
ROBERT LANCASTER | | 15. MOTHER'S MAIDEN NAME First Middle Last
MARY ANN CROSS | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> (If yes give year or dates of service) N.A. | | | |
| 16b. SOCIAL SECURITY NO.
214-07-5748 | | 17. INFORMANT Address MARYLAND
MRS. GUY MALLOW, 68 HILL ST., FROSTBURG, | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4109 Coronary occlusion
DUE TO, OR AS A CONSEQUENCE OF -
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic CVD -
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
24 hrs - 4 years | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
4201 | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from April , 19 68 , to May 10 , 19 68 , that (I) (we) last saw the deceased alive on May 10 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
J.B. Davis, MD. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | 22c. DATE SIGNED
5/13/68 | | | |
| 22d. PHYSICIAN'S NAME (Type)
JOHN B. DAVIS, M.D. | | | | 22e. ADDRESS
2 BROADWAY, FROSTBURG, MD. 21532 | | | |
| 23a. BURIAL, CREMATION, REMOVA (Specify) | | 23b. DATE
MAY 13, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
ECKHART CEMETERY | | 23d. LOCATION (City or Town) (County) (State)
ECKHART ALLEGANY, MD. | |
| 24. FUNERAL DIRECTOR
MARILYN M. SOWERS HOME, 60 W. MAIN, FROSTBURG | | | | 25a. REC'D BY REGISTRAR
MAY 17 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

OFFICE OF THE ATTORNEY GENERAL

1880

JOSEPH W. KENNEDY, MAY 10, 1880

DEPT. OF JUSTICE, WASHINGTON, D.C.

RECEIVED, MAY 10, 1880

RECEIVED, MAY 10, 1880

RECEIVED, MAY 10, 1880

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RECEIVED, MAY 10, 1880

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|------------------------------------------------------------------------------|------------------------------------------------------------------------------|---------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-----------------------------------------------|-------------------------------------------------------------------------------------------|---------------------------------------------------------|----------|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or Print) | | | First | | Middle | | Last | | 2a. DATE KNOWN OF ESTI-
DEATH MATED <input checked="" type="checkbox"/> Month Day Year | | 2b. HOUR |
| Ralph | | | Carlton | | Lashbaugh, Jr. | | | | May 6, 1968 | | 8:30 P |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (In years lost birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | 2c. DATE PRONOUNCED DEAD
Month Day Year | |
| Male | White | Oct. 23, 1939 | | 28 YRS. | | | | | | May 6, 1968 8:30 P | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | 2d. HOUR | |
| Maryland | | | U. S. A. | | | | | Allegany | | | Md. |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Frostburg | | | 97 Bowery Street | | | Laborer | | | Brewery Queen City | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | |
| Maryland | | | Allegany | | Frostburg | | | | 97 Bowery Street | | |
| 14. FATHER'S NAME | | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME | | |
| Ralph | | | Carlton | | Lashbaugh Sr. | | Mary | | Margaret Leasure | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | | |
| No | | | 216-38-1863 | | Mrs. Mary Margaret Lashbaugh Frostburg, Md. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>GUNSHOT OF CHEST</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>(SELF INFLICTED)</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
MINUTES | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>976x</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M.
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. | | | City or Town | | County State | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>Benedict Skitarelic</u> | | | EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D. | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED May 6, 1968 | | |
| | | | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | |
| | | | | | | ADDRESS (Street, city, town, or county) CUMBERLAND, MARYLAND | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | | May 10, 1968 | | Frostburg Memorial Park | | | Frostburg Alleg. Md. | | | |
| 24. FUNERAL DIRECTOR | | | ADDRESS | | | 25a. REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | |
| John J. Hafer, Jr. | | | 230 Balto Ave. Cumberland | | | MAY 9 1968 | | | Charles Judge | | |

61360

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------|--|
| 1. DECEASED-NAME (Type or print) JAMES | | First Middle Last Franklin LEASE | | 2a. DATE OF DEATH MAY 12, 1968 | | 2b. HOUR 7:30 P M | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH 9-12-1890 | | 6. AGE (In years last birthday) 77 YRS. | |
| 7a. BIRTHPLACE (State or foreign country) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH ALLEGANY Md. | |
| 10. CITY OR TOWN OF DEATH CUMBERLAND | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired B & O Employee | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) MARYLAND | | 13b. COUNTY ALLEGANY | | 13c. CITY OR TOWN CUMBERLAND | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET AND NUMBER RT. #3, BOX 630 | | 13f. EASTMAN RD. | | | | | |
| 14. FATHER'S NAME First Middle Last JAMES LEASE | | 15. MOTHER'S MAIDEN NAME First Middle Last MARY JANE CALDWELL | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) Yes WW I | | 16b. SOCIAL SECURITY NO. 220-10-2187 | | 17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of prostate
185X DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____ DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH unknown | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
177X General arteriosclerosis | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year 19 P.M. | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/8, 1968 , to 5/12, 1968 , that (I) (we) last saw the deceased alive on 5/12, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE S. G. Weisman | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 5/14/68 | | | |
| 22d. PHYSICIAN'S NAME (Type) DR. S. G. WEISMAN | | 22e. ADDRESS CUMBERLAND, MD. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 5/15/68 | | 23c. NAME OF CEMETERY OR CREMATORY Pleasant Grove Cemetery | | 23d. LOCATION (City or Town) (County) (State) Cumberland Alleg Maryland | |
| 24. FUNERAL DIRECTOR ADDRESS H. Lee Silcox Cumberland, Maryland 21502 | | | | 25a. REC'D BY REGISTRAR DATE MAY 16 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

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James

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W. E.

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MEMORIAL

W. E.

W. E.

W. E.

James

James

James

James

W. E.

W. E.

W. E.

W. E.

DR. G. G. WEISBERG

CHURCHMAN, MO.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
 CERTIFICATE OF DEATH

06420

06426

| | | | | | | | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------|--|-------------------------------------------------|--|
| 1. DECEASED-NAME
(Type or print) | | First
Bridget | | Middle
A. | | Last
Mason | | 2a. DATE OF DEATH
May Month 20 Day 1968 Year | | 2b. HOUR
8:40 | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
Feb. 22, 1884 | | 6. AGE (In years
last birthday)
84 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign
country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Allegany | | | | | |
| 10. CITY OR TOWN OF DEATH
Cumberland | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
Sylvan Retreat | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
Housewife | | 12b. KIND OF BUSINESS OR
INDUSTRY
Own Home | | | | | |
| 13a. USUAL RESIDENCE (Where deceased
admission) STATE
Maryland | | 13b. COUNTY
Allegany | | 13c. CITY OR TOWN
Cumberland | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
925 Grand Avenue | | | |
| 14. FATHER'S NAME
First
Patrick | | Middle
Nelson | | Last
Nelson | | 15. MOTHER'S MAIDEN NAME First
Margaret | | Middle
Kelly | | Last
Kelly | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown)
no | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service) | | 17. INFORMANT
James Mason, Cumberland, Md. Son | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Carcinoma Rectum</u>
1541 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last. (b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
154x | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,)
OFFICE BUILDING, ETC. | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>April 15, 1967</u> to <u>May 20, 1968</u> , that (I) (we) last
saw the deceased alive on <u>May 19, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>George M. Simons</u> | | DEGREE | | ATTENDING
PHYS. | | MED.
DIRECTOR <input checked="" type="checkbox"/> | | STAFF
PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
5/21/68 | |
| 22d. PHYSICIAN'S
NAME (Type)
George M. Simons, M.D. | | 22e. ADDRESS
Memorial Hospital, Cumberland, Md. 21502 | | | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial | | 23b. DATE
May 24, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Mary's Cemetery | | 23d. LOCATION (City or Town)
Cumberland, Md. | | (County)
Allegany | | (State) | |
| 24. FUNERAL DIRECTOR
James F. Scarpelli, Cumberland, Md. | | ADDRESS | | 25a. REC'D BY REGISTRAR
JUN 3 1968 | | 25b. REGISTRAR'S SIGNATURE
<u>James F. Scarpelli</u> | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
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| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) First Middle Last
JACOB G. MEYERS | | | 2a. DATE OF DEATH
Month 05 Day 06 Year 68 | | | 2b. HOUR
10:16 AM | | | | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
11-27-92 | | 6. AGE (In years last birthday)
75 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (State or foreign country)
PENNSYLVANIA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
ALLEGANY COUNTY, Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
CUMBERLAND | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
SACKED HEART HOSPITAL | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
ENGINEER | | 12b. KIND OF BUSINESS OR INDUSTRY
RAILROAD | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MARYLAND | | 13b. COUNTY
ALLEGANY | | 13c. CITY OR TOWN
CUMBERLAND | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
RT. #4, BOX 33, OLDTOWN RD. | | | |
| 14. FATHER'S NAME First Middle Last
GEORGE M. MEYERS | | | 15. MOTHER'S MAIDEN NAME First Middle Last
BURKEHART, EFFIE MEYERS | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or unknown | | 16b. SOCIAL SECURITY NO.
705-07-6628 | | 17. INFORMANT Address
HOSPITAL RECORDS-900 SETON DR., CUMB., MD. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>myocardial infarction</u>
4109 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Arterio-sclerosis</u>
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4201 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Clarence J. Vincent M.D. | | | | | | | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (Type)
Clarence J. Vincent, MD | | | | 22e. ADDRESS
126 N. SMALLWOOD ST., CUMB., MD. 21502 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE
May 10, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Davis Memorial Park | | 23d. LOCATION (City or Town) (County) (State)
Cumberland, Allegany, Md. | | | | | |
| 24. FUNERAL DIRECTOR
SCARPELL FUNERAL HOME, 108 VIRGINIA AVE. | | | | 25a. REC'D BY REGISTRAR
DATE MAY 10 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | |

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UNITED STATES OF AMERICA

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
30M REV. 1/68

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|----------------------------------------------------------------------------------------------------------|--|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|-------------------------------------------------------------------------------------------------|--|--|----------------------------------------------------------------------|--|--------------------------------|-------------------------|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First
CLEMENT | | | Middle
H. | | | Last
MILLER | | | 2a. DATE OF DEATH
Month MAY Day 24 Year 1968 | | | 2b. HOUR
3:55 | | | |
| 3. SEX
MALE | | | 4. RACE
WHITE | | | 5. DATE OF BIRTH
OCTOBER 29, 1914 | | | 6. AGE (In years)
last birthday 53 YRS. | | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | | | |
| 7a. BIRTHPLACE (State or foreign country)
W. VA. | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
ALLEGANY | | | | | Md. | | | | |
| 10. CITY OR TOWN OF DEATH
CUMBERLAND | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
MEMORIAL HOSPITAL | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Scrap Dealer | | | 12b. KIND OF BUSINESS OR INDUSTRY
Own | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MARYLAND | | | 13b. COUNTY
ALLEGANY | | | 13c. CITY OR TOWN
CUMBERLAND | | | 13d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | 13e. STREET AND NUMBER
239 HUMBLD STREET | | | | | | |
| 14. FATHER'S NAME
First EDWARD Middle MILLER Last ROACH | | | 15. MOTHER'S MAIDEN NAME
First MYRTLE Middle ROACH Last ROACH | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown no | | | 16b. SOCIAL SECURITY NO.
214-05-8998 | | | 17. INFORMANT
Address
MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Pulmonary Embolism
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes Mellitus, Nutritional Deficiency
DUE TO, OR AS A CONSEQUENCE OF (c) Myocardial Infarction
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 hrs | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
465 x Diabetes Mellitus, Nutritional Deficiency | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. (If YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?) | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
WCS [Signature] | | | 22c. DATE SIGNED
5/24/68 | | | 22d. PHYSICIAN'S NAME (Type)
BRAD. MED. GROUP. | | | 22e. ADDRESS
127 N. S. [Signature] Cumberland Md. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE
May 27, 1968 | | | 23c. NAME OF CEMETERY OR CREMATORY
Davis Memorial Cemetery | | | 23d. LOCATION (City or Town) (County) (State)
Cumberland, Allegany, Md. | | | | | | | | | |
| 24. FUNERAL DIRECTOR
James F. Scarpelli, Cumberland, Md. | | | 25a. REC'D BY REGISTRAR
DATE MAY 29 1968 | | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | | | | | | | | | | |

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OCTOBER 20, 1914

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MALE

ALLEGANY

U.S.A.

W.VA.

MEMORIAL HOSPITAL

CUMBERLAND

239 HUNTING STREET

ALLEGANY, CUMBERLAND

MARYLAND

BOACH

MYRTLE

MILLER

BEHARD

MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND

BRAD. MED. GROUP

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|----------------------------------------------------------------------------------------------|-----|-----------------------------------|----------|
| 1. DECEASED-NAME
(Type or Print) | | First | Middle | Last | 2a. DATE KNOWN OF DEATH | <input checked="" type="checkbox"/> Month | Day | Year | 2b. HOUR |
| Bernice | | | | Morehead | OF ESTI-DEATH MATED | <input type="checkbox"/> MAY | 25 | 1968 | 5:06P |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN. | 2c. DATE PRONOUNCED DEAD | | 2d. HOUR | |
| Female | White | Oct. 20, 1894 | 73 YRS. | | | Month | Day | Year | |
| | | | | | | MAY | 25 | 1968 | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Winterburn Penna. | | U.S.A. | | | | Allegany | | Md. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Cumberland Md. | | MEMORIAL HOSPITAL-DOA | | Housewife | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Maryland | | Allegany | | Rural Cumberland | | | | R.F.D. #3 Bedford Rd. | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| Harry F. Askey | | Abbie B. Hilshire | | NO | | | | Mr. Curtis O. Gilpin. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4109
DUE TO, OR AS A CONSEQUENCE OF
CORONARY OCCLUSION
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
CORONARY SCLEROSIS
(c) | | | | | | SUDDEN | | ---- | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) | | 4201 | | | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M.
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | |
| | | | | | | | | State | |
| 22a. I certify that I took charge of the remains described above, held on | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: | | Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE | | Benedict Skitarellic | | M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22b. DATE SIGNED | |
| EXAMINER'S NAME (Type) | | BENEDICT SKITARELIC, M.D. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | MAY 25, 1968 | |
| | | | | | | ADDRESS (Street, city, town, or county) | | CUMBERLAND, MARYLAND | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) (State) | |
| Burial | | May, 27, 1968 | | Zion Memorial Park. | | Cumberland (allegany) | | Maryland | |
| 24. FUNERAL DIRECTOR | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Louis Stein Inc | | Cumberland Md | | MAY 28 1968 | | Charles Judge | | | |

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• *Journal of the American Academy of Child and Adolescent Psychiatry*

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2000

Anna B. Lloyd

1991-1992

1. *Chlorophyll a* (Chl a) and *Chlorophyll b* (Chl b) are the two main photosynthetic pigments in green plants. They are responsible for capturing light energy and converting it into chemical energy through the process of photosynthesis. Chl a is the primary pigment, while Chl b acts as an accessory pigment, transferring energy to Chl a.

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1730 1830 1930 2030 2130 2230 2330 2430 2530 2630 2730 2830 2930 3030 3130 3230 3330 3430 3530 3630 3730 3830 3930 4030 4130 4230 4330 4430 4530 4630 4730 4830 4930 5030 5130 5230 5330 5430 5530 5630 5730 5830 5930 6030 6130 6230 6330 6430 6530 6630 6730 6830 6930 7030 7130 7230 7330 7430 7530 7630 7730 7830 7930 8030 8130 8230 8330 8430 8530 8630 8730 8830 8930 9030 9130 9230 9330 9430 9530 9630 9730 9830 9930 10030 10130 10230 10330 10430 10530 10630 10730 10830 10930 11030 11130 11230 11330 11430 11530 11630 11730 11830 11930 12030 12130 12230 12330 12430 12530 12630 12730 12830 12930 13030 13130 13230 13330 13430 13530 13630 13730 13830 13930 14030 14130 14230 14330 14430 14530 14630 14730 14830 14930 15030 15130 15230 15330 15430 15530 15630 15730 15830 15930 16030 16130 16230 16330 16430 16530 16630 16730 16830 16930 17030 17130 17230 17330 17430 17530 17630 17730 17830 17930 18030 18130 18230 18330 18430 18530 18630 18730 18830 18930 19030 19130 19230 19330 19430 19530 19630 19730 19830 19930 20030 20130 20230 20330 20430 20530 20630 20730 20830 20930 21030 21130 21230 21330 21430 21530 21630 21730 21830 21930 22030 22130 22230 22330 22430 22530 22630 22730 22830 22930 23030 23130 23230 23330 23430 23530 23630 23730 23830 23930 24030 24130 24230 24330 24430 24530 24630 24730 24830 24930 25030 25130 25230 25330 25430 25530 25630 25730 25830 25930 26030 26130 26230 26330 26430 26530 26630 26730 26830 26930 27030 27130 27230 27330 27430 27530 27630 27730 27830 27930 28030 28130 28230 28330 28430 28530 28630 28730 28830 28930 29030 29130 29230 29330 29430 29530 29630 29730 29830 29930 30030 30130 30230 30330 30430 30530 30630 30730 30830 30930 31030 31130 31230 31330 31430 31530 31630 31730 31830 31930 32030 32130 32230 32330 32430 32530 32630 32730 32830 32930 33030 33130 33230 33330 33430 33530 33630 33730 33830 33930 34030 34130 34230 34330 34430 34530 34630 34730 34830 34930 35030 35130 35230 35330 35430 35530 35630 35730 35830 35930 36030 36130 36230 36330 36430 36530 36630 36730 36830 36930 37030 37130 37230 37330 37430 37530 37630 37730 37830 37930 38030 38130 38230 38330 38430 38530 38630 38730 38830 38930 39030 39130 39230 39330 39430 39530 39630 39730 39830 39930 40030 40130 40230 40330 40430 40530 40630 40730 40830 40930 41030 41130 41230 41330 41430 41530 41630 41730 41830 41930 42030 42130 42230 42330 42430 42530 42630 42730 42830 42930 43030 43130 43230 43330 43430 43530 43630 43730 43830 43930 44030 44130 44230 44330 44430 44530 44630 44730 44830 44930 45030 45130 45230 45330 45430 45530 45630 45730 45830 45930 46030 46130 46230 46330 46430 46530 46630 46730 46830 46930 47030 47130 47230 47330 47430 47530 47630 47730 47830 47930 48030 48130 48230 48330 48430 48530 48630 48730 48830 48930 49030 49130 49230 49330 49430 49530 49630 49730 49830 49930 50030 50130 50230 50330 50430 50530 50630 50730 50830 50930 51030 51130 51230 51330 51430 51530 51630 51730 51830 51930 52030 52130 52230 52330 52430 52530 52630 52730 52830 52930 53030 53130 53230 53330 53430 53530 53630 53730 53830 53930 54030 54130 54230 54330 54430 54530 54630 54730 54830 54930 55030 55130 55230 55330 55430 55530 55630 55730 55830 55930 56030 56130 56230 56330 56430 56530 56630 56730 56830 56930 57030 57130 57230 57330 57430 57530 57630 57730 57830 57930 58030 58130 58230 58330 58430 58530 58630 58730 58830 58930 59030 59130 59230 59330 59430 59530 59630 59730 59830 59930 60030 60130 60230 60330 60430 60530 60630 60730 60830 60930 61030 61130 61230 61330 61430 61530 61630 61730 61830 61930 62030 62130 62230 62330 62430 62530 62630 62730 62830 62930 63030 63130 63230 63330 63430 63530 63630 63730 63830 63930 64030 64130 64230 64330 64430 64530 64630 64730 64830 64930 65030 65130 65230 65330 65430 65530 65630 65730 65830 65930 66030 66130 66230 66330 66430 66530 66630 66730 66830 66930 67030 67130 67230 67330 67430 67530 67630 67730 67830 67930 68030 68130 68230 68330 68430 68530 68630 68730 68830 68930 69030 69130 69230 69330 69430 69530 69630 69730 69830 69930 70030 70130 70230 70330 70430 70530 70630 70730 70830 70930 71030 71130 71230 7

4. 1995

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------|----------------------------------------------------------------------------------------------------------|------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|--|---------------------------------------------------------------|--|--|
| 1. DECEASED-NAME
(Type or print) First HARRY Middle W. Last NOEL | | | 2a. DATE OF DEATH
Month MAY Day 27 , 19 68 Year 1968 | | | 2b. HOUR 6:30 A. M | | | | | | | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
AUG. 17, 1899 | | 6. AGE (In years last birthday)
68 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | | | |
| 7a. BIRTHPLACE (State or foreign country)
WESTERNPORT, MD. | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
ALLEGANY Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
CUMBERLAND | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
MEMORIAL HOSPITAL | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
NIGHT WATCHMAN | | | 12b. KIND OF BUSINESS OR INDUSTRY
HOSPITAL | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND 13b. COUNTY ALLEGANY | | | 14. FATHER'S NAME First HENRY Middle Last NOEL | | | 15. MOTHER'S MAIDEN NAME First SARAH Middle Last LEASE | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, on or after (date) YES (If yes give war or dates of service) WW 1 | | | 16b. SOCIAL SECURITY NO.
213-09-6434 | | |
| 17. INFORMANT
MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND | | | 18. CITY OR TOWN
FROSTBURG | | | 19. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 20. STREET AND NUMBER
RT. #2 | | | 21. ADDRESS
MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND | | |
| 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 2049 Symptomatic Leukemia
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Since 11/20/66 | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
2040 Diabetes Mellitus Pneumonia & Embolus | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION
11-20-66 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Pneumonia & Embolus | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
YES | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year 1968
P.M. | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)
 | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Nat while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
 | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11-20-66 to 5/27/68 , that (I) (we) last saw the deceased alive on 5-26-68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 22b. SIGNATURE
W.F. Williams | | | 22c. DATE SIGNED
5/27/68 | | | 22d. PHYSICIAN'S NAME (Type)
DR. W.F. WILLIAMS | | | | | | | | |
| 22e. ADDRESS
122 SO. CENTRE STREET, CUMBERLAND | | | 22f. ADDRESS
MD. | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | | 23b. DATE
MAY 30 '68 | | | 23c. NAME OF CEMETERY OR CREMATORY
ECKHART CEMETERY | | | 23d. LOCATION (City or Town) (County) (State)
ECKHART, MD. | | | | | |
| 24. FUNERAL DIRECTOR
JOSEPH R. DURST, SR., FROSTBURG, MD. 21532 | | | 25a. REC'D BY REGISTRAR
DATE MAY 31 1968 | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | | | | |

06430

CENTRAL OF DEATH

06430

2, 1903 0:30

1 WAY

ROEL

W.

HARRY

WIFE

WHITE

AUG 13, 1903

40

ALLEGANY

WESTBROOK, N.Y.

CORNER

MEMORIAL HOSPITAL

ST. BARNABAS

MARYLAND

ALLEGANY

WESTBROOK

ST. BARNABAS

HENRY

ROEL

SARAH

LEASE

MEMORIAL HOSPITAL, CORNER, WESTBROOK, N.Y.

ST. BARNABAS

ST.

DR. W. A. VILLIERS

123 201 CENTRE STREET, CORNER, N.Y.

MAY 20 1903

ST. BARNABAS

ST. BARNABAS

ST. BARNABAS

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FOR STATE HEALTH DEPT.

Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 723. Page 5 may be retained for your files.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------|--|
| 06425 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | 06431 | |
| 1. DECEASED-NAME (Type or Print) | | First | | Middle | | Last | |
| CLOYD | | O'NEAL | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | |
| MALE | | WHITE | | FEB. 1, 1902 | | 66 YRS. | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | |
| PENNA. | | USA | | | | ALLEGANY Md. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| CUMBERLAND | | MEMORIAL HOSPITAL | | OPERATOR | | TIRE | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| MARYLAND | | ALLEGANY | | CUMBERLAND | | 913 FREDERICK STREET | |
| 14. FATHER'S NAME | | First | | Middle | | Last | |
| HARTMAN | | O'NEAL | | HESTER | | WILLIAMS | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| NO | | 214 07 1140 | | JEAN O'NEAL | | CUMBERLAND, MD. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | Cerebral Hemorrhage | | 5 Hours | | | |
| 4129 | | DUE TO, OR AS A CONSEQUENCE OF | | Cerebral Hemorrhage | | 5 Hours | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | (b) | | Arteriosclerotic cardio-vascular disease | | ----- | |
| (c) | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | 4221 | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22b. DATE SIGNED | | | |
| ACTUAL SIGNATURE <i>Benedict Skitarelic</i> M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | 5/21/68 | | | |
| EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D. | | RT. 9, CUMBERLAND, MD. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE 5/24/68 | | 23c. NAME OF CEMETERY OR CREMATORY SUNSET MEMORIAL PARK | | 23d. LOCATION (City or Town) (County) (State) CUMBERLAND, MD. | |
| 24. FUNERAL DIRECTOR BYRON KIGHT | | ADDRESS CUMBERLAND, MD. | | 25a. REC'D BY REGISTRAR MAY 27 1968 | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | |

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200:0 11 244

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR-1310
30M REV. 1/68

06426

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06432

| | | | | | | | | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------|---------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|-----------------------------------------------------------------------------------|--------|--------------------------------|-------|
| 1. DECEASED-NAME
(Type or print) | | First | Middle | Lost | 20. DATE OF DEATH | | 2b. HOUR | | | | |
| HUGH | | M | OROURKE | | Month Day Year
MAY 23 1968 | | AM 4:14 | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years
lost birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| MALE | | WHITE | | 10-30-1905 | | 62 YRS. | | | | | |
| 7a. BIRTHPLACE (State or foreign
country) | | 7b. CITIZEN OF WHAT COUNTRY? | | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| MIDLAND, MD. | | USA | | | | ALLEGANY COUNTY Md. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | | | |
| CUMBERLAND | | MEMORIAL HOSPITAL | | B & O R. R. BLACKSMITH | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | | |
| MD. | | ALLEGANY | | CUMBERLAND | | | | 202 COLUMBIA ST. | | | |
| 14. FATHER'S NAME | | First | Middle | Lost | 15. MOTHER'S MAIDEN NAME | | First | Middle | Lost | | |
| JOHN | | T | OROURKE | | MARY | | | KRAMER | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) | | (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | | |
| NO | | | | 705 05 4645 | | MEMORIAL HOSPITAL, CUMBERLAND, MD. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Massive intracerebral hemorrhage</u>
<u>431.9</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
lost. <u>331.9</u>
(b) <u>Cerebrovascular</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u></u> | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
<u>3-4 hrs</u>
<u>5 yrs</u> | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
<u>Osteoarthritis of Spine</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>August, 1967</u> , to <u>5/22, 1968</u> , that (I) (we) last
saw the deceased alive on <u>5/1, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING
PHYS. | | <input checked="" type="checkbox"/> MED.
DIRECTOR <input type="checkbox"/> STAFF
PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED | | | |
| 22d. PHYSICIAN'S
NAME (Type) | | DR. S. G. WEISMAN | | 22e. ADDRESS | | 59 GREENE ST., CUMBERLAND, MD. | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) | | (State) | |
| BURIAL | | MAY 25, 1968 | | SUNSET MEMORIAL PARK | | CUMBERLAND, MD. | | | | | |
| 24. FUNERAL DIRECTOR | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| BYRON KIGHT | | CUMBERLAND, MD. | | DATE | | MAY 27 1968 | | <u>Charles Judge</u> | | | |

08433

08433

HUGH M. GORRUCK MAY 23 1968 MTH

WILEY WHITE 10-00-1903
MIDLAND, NC. USA
CUMBERLAND
MEMORIAL HOSPITAL
ALLEGANY CUMBERLAND X
205 COLUMBIA ST.
JOHN J. GORRUCK
205 C. MEMORIAL HOSPITAL, CUMBERLAND, MD.
KRUMER

DR. S. B. WEISSMAN
29 GREEN ST., CUMBERLAND, MD.
CUMBERLAND, MD.
CUMBERLAND, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A13.4
30M REV. 7-68

1
06427
MAY 12 1968
MAY 15 1968

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|--------------------------------------------------------------------|
| 1. DECEASED-NAME (Type or print) Ida First Middle Last | | | 2a. DATE OF DEATH May Month 12 Day 1968 Year | | 2b. HOUR 8 P.M. |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH aug. 8, 1881 | | 6. AGE (In years last birthday) 86 YRS. | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country) Maryland | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH Allegany Md. | | |
| 10. CITY OR TOWN OF DEATH Westernport | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 78 Main | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) house wife | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | 13b. COUNTY Allegany | 13c. CITY OR TOWN Westernport | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER 78 Main | |
| 14. FATHER'S NAME First Middle Last Solamon Martin | | 15. MOTHER'S MAIDEN NAME First Middle Last Christina Dagatree | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or unknown <input type="checkbox"/> (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address Howard Peyton Westernport, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4109 Myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized ASCVD
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes 25 yr. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201 | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept. 1964 , to 5-12, 1968 , that (I) (we) lost saw the deceased alive on 5-10-1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE William W. Lesh MD DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | 22c. DATE SIGNED May 13 1968 | |
| 22d. PHYSICIAN'S NAME (Type) William W. Lesh | | 22e. ADDRESS Westernport, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 2/12/68 | 23c. NAME OF CEMETERY OR CREMATORY Philos | | 23d. LOCATION (City or Town) (County) (State) Westernport Md. | |
| 24. FUNERAL DIRECTOR E. J. Boal ADDRESS Westernport, Md. | | 25a. REC'D BY REGISTRAR DATE MAY 15 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 2133. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, prior to burial, cremation, or removal, and in any event within 72 hours after death.

06423

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06434

| | | | | | | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------|-----------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|-------------------------------------------------------------------|-------------------|
| 1. DECEASED-NAME
(Type or Print) First Middle Last
Roland Jonathan Ramhoff | | | 2a. DATE KNOWN OF DEATH
MAY 31, 1968
Month Day Year | | | 2b. HOUR
11 AM | | | |
| 3. SEX
Male | 4. RACE
Cau. | 5. DATE OF BIRTH
Sept. 25, 1885 | 6. AGE (in years last birthday)
82 YRS. | IF UNDER 1 YEAR
MONTHS DAYS | IF UNDER 24 HRS
HOURS MIN. | 2c. DATE PRONOUNCED DEAD
MAY 31, 1968
Month Day Year | | | 2d. HOUR
11 AM |
| 7a. BIRTHPLACE (State or foreign country)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Allegany | | | |
| 10. CITY OR TOWN OF DEATH
Cumberland | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Sacred Heart Hosp. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Carpenter | | | 12b. KIND OF BUSINESS OR INDUSTRY
Self-employed | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | 13b. COUNTY
Allegany | | 13c. CITY OR TOWN
Bowling Green | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
4 Wrights Ave. Bowling Green | |
| 14. FATHER'S NAME First Middle Last
Charles Ramhoff | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Rebecca Bitteringer | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown)
No | | 16b. SOCIAL SECURITY NO.
220-10-8834 | | 17. INFORMANT
Mr. Charles A. Ramhoff | | | ADDRESS
Wrights Ave. Bowling Green | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 600X ACUTE PULMONARY EDEMA
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
(b) CHRONIC GLOMERULONEPHRITIS
DUE TO, OR AS A CONSEQUENCE OF
(c) OBSTRUCTIVE PROSTATIC HYPERTROPHY | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
30 MINUTES | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)
610X | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. P.M.
19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE
Benedict Skitarelic
EXAMINER'S NAME (Type)
BENEDICT SKITARELIC, M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
MAY 31, 1968
ADDRESS (Street, city, town, or county)
CUMBERLAND, MARYLAND | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
6/3/68 | | 23c. NAME OF CEMETERY OR CREMATORY
White Oak Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Wellersburg, Somerset, Penna. | | | |
| 24. FUNERAL DIRECTOR
H. Wayne George | | | | ADDRESS
Cumberland, Md. | | 25a. REC'D BY REGISTRAR
DATE
JUN 4 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1 and 2 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1-100. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|------------------------------------------------------------------------------|--------|----------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|------------------|----------------------------------------------------------------------------------|----------------------------------------------|
| 1. DECEASED-NAME
(Type or Print) | | First | Middle | Last | 2a. DATE KNOWN <input checked="" type="checkbox"/> Month Day Year | | | | 2b. HOUR |
| WILDA | | FRANCES | RAINES | 2c. DATE OF DEATH ESTI- MATED <input type="checkbox"/> May 13, 1968 | | | | 4:4 | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | 2d. HOUR |
| Female | White | Feb. 2, 1906 | | 62 YRS. | MONTHS DAYS | | HOURS MIN. | | 4:4 |
| 7a. BIRTHPLACE (State or foreign country) W, Va. | | 7b. CITIZEN OF WHAT COUNTRY? U. S. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | Md. |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Cumberland | | Memorial Hospital-DOA | | | Housewife | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| | | Allegany | | Cumberland | | | | 204 Springdale Street | |
| 14. FATHER'S NAME | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | First | Middle | Last |
| Peter | | Lee | Lewis | | Iona | | Etta | McBride | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16b. SOCIAL SECURITY NO. (If yes give war or dates of service) | | 17. INFORMANT | | ADDRESS | | | |
| | | 215-20-7271 | | Wilda R. Thomas, | | Romney, W, Va. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion | | | | | | | | | Sudden |
| 4109 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Sclerosis | | | | | | | | | ---- |
| (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 4201 | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | State |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE <i>Benedict Skitarelic</i> | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22b. DATE SIGNED | | | |
| EXAMINER'S NAME (Type) Benedict Skitarelic, M.D. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | May 13, 1968 | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | ADDRESS (Street, city, town, or county) Cumberland, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | May 15, 1968 | | Ebenezer | | Romney Hampshire W, Va. | | | |
| 24. FUNERAL DIRECTOR <i>South Shuff</i> | | | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| | | | | Romney, W, Va. | | MAY 15 1968 | | <i>Charles Judge</i> | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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06430

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06438

| | | | | | | | | | | | | | | | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|---------------------------------------------------------------------------------------------------------------------------------------------------|--|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|----------------------------------------------------------------------------------------------|--|--|------------------------------------------------------------------------|--|--|------------------------------------------------|--|--|--|
| 1. DECEASED-NAME
(Type or print) RUTH | | | First N. | | | Middle ROBERTSON | | | Last | | | 2a. DATE OF DEATH
Month MAY Day 30 , Year 1968 | | | 2b. HOUR 8:25 MIN AM | | | |
| 3. SEX
FEMALE | | | 4. RACE
WHITE | | | 5. DATE OF BIRTH
JULY 27, 1895 | | | 6. AGE (In years lost 72 hdy)
72 YRS. | | | IF UNDER 1 YEAR
MONTHS DAYS | | | IF UNDER 24 HRS.
HOURS MIN. | | | |
| 7a. BIRTHPLACE (State or foreign country)
ELLERSUE, MD. U.S.A. | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
ALLEGANY Md. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
CUMBERLAND, | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
MEMORIAL HOSPITAL | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
HOUSEWIFE | | | 12b. KIND OF BUSINESS OR INDUSTRY
OWN HOME | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND | | | 13b. COUNTY ALLEGANY | | | 13c. CITY OR TOWN ELLERSLIE | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER
NONE | | | | | | |
| 14. FATHER'S NAME First GRIFFEY, Middle L. Last CHARLES | | | 15. MOTHER'S MAIDEN NAME First EMMA Middle C. Last COLEMAN | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO.
217 10 6005 | | | 17. INFORMANT
MEMORIAL HOSPITAL | | | Address
CUMBERLAND, MARYLAND | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Intractable Congestive Heart Failure
398X
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Hypertensive Cardiovascular Disease
DUE TO, OR AS A CONSEQUENCE OF
(c) due to Rheumatic Heart Disease
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
week
years | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
416X | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1961 , 19 May , 1968, that (I) (we) last saw the deceased alive on May 29 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
<i>[Signature]</i> | | | DEGREE DR. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED
5-30-68 | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
DR. B. O. HIMMELWRIGHT | | | 22e. ADDRESS
133 VIRGINIA AVE., CUMBERLAND, MD. | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | | 23b. DATE
JUNE 1, 1968 | | | 23c. NAME OF CEMETERY OR CREMATORY
ROSE HILL CEMETERY | | | 23d. LOCATION (City or Town) (County) (State)
CUMBERLAND, MD. | | | | | | | | | |
| 24. FUNERAL DIRECTOR
BYRON KIGHT | | | ADDRESS
CUMBERLAND, MD. | | | 25a. REC'D BY REGISTRAR
DATE JUN 3 1968 | | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | | | | | | | |

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------|----------------------------------------------------------------------------------|----------------------------------------------------------|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or Print) | | | First | | Middle | | Last | | |
| ROBERT | | | FRANCIS | | SEVERSON, SR. | | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | 20. DATE KNOWN OF DEATH ESTIMATED |
| MALE | WHITE | APRIL 23, 1911 | | 57 YRS. | | | | | <input checked="" type="checkbox"/> MAY 20, 1988 9:50 AM |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | |
| PHILADELPHIA PA. | | | U.S.A. | | | | ALLEGANY Md. | | |
| 10. CITY OR VILLAGE (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| MIDLOTHIAN | | | MINER'S HOSPITAL--DOA | | | TILE HELPER | | | CONSTRUCTION |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | |
| MARYLAND | | | BALTIMORE | | | | | 8008 CHARLES MONT, ROAD | |
| 14. FATHER'S NAME | | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME |
| ROBERT | | | FRANCIS | | SEVERSON | | MARY | | DOCKETEY |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | |
| NO | | | N.A. | | | 21221) MONT. RD. BALT. CO. MD. | | | |
| | | | 169-16-2869 | | | ROBERT FRANCIS SEVERSON, 8008 CHARLES | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | SUDDEN |
| IMMEDIATE CAUSE (a) <u>410.9</u> CORONARY OCCLUSION, RIGHT | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (b) CORONARY THROMBOSIS, RIGHT | | | | | | | | | " |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) CORONARY SCLEROSIS | | | | | | | | | ---- |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) | | | | | | | | | |
| <u>4201</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M.
P.M. | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | 19 | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE <u>Benedict Skitaralic</u> | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22b. DATE SIGNED | | | |
| EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | MAY 20, 1968 | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | ADDRESS (Street, city, town, or county) CUMBERLAND, MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 5-24-68 | | Sacred Heart Cem. | | Baltimore Md. | | | |
| 24. NAME OF REGISTRAR | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| MARION M. SOWERS | | | | HOME, 60 W. MAIN, FROSTBURG | | MAY 24 1968 Charles Judge | | | |

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HEALTH DEPT
WASHINGTON

NAME: WHITE, JAMES
DOB: 1911
RES: 1234 5th St, N.W.
CITY: WASHINGTON, D.C.
STATE: DISTRICT OF COLUMBIA
OCCUPATION: BELLMAN
REMARKS: I have been employed as a bellman for the past 10 years. I am a native born American and have no other health problems.

NAME: WHITE, JAMES
DOB: 1911-10-28
RES: 1234 5th St, N.W.
CITY: WASHINGTON, D.C.
STATE: DISTRICT OF COLUMBIA
OCCUPATION: BELLMAN
REMARKS: I have been employed as a bellman for the past 10 years. I am a native born American and have no other health problems.

NAME: WHITE, JAMES
DOB: 1911-10-28
RES: 1234 5th St, N.W.
CITY: WASHINGTON, D.C.
STATE: DISTRICT OF COLUMBIA
OCCUPATION: BELLMAN
REMARKS: I have been employed as a bellman for the past 10 years. I am a native born American and have no other health problems.

NAME: WHITE, JAMES
DOB: 1911-10-28
RES: 1234 5th St, N.W.
CITY: WASHINGTON, D.C.
STATE: DISTRICT OF COLUMBIA
OCCUPATION: BELLMAN
REMARKS: I have been employed as a bellman for the past 10 years. I am a native born American and have no other health problems.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A75 (4)
30M REV. 1/68

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------|------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|-----------------------------------|----------------------------------------------|
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR |
| CHARLES DANIEL SHAFFER | | | | | | Month Day Year
05 21 68 | | | 3:20P ^M |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS |
| MALE | | WHITE | | 04-10-93 | | | 75 YRS. | | IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| MARYLAND | | USA | | | | ALLEGANY COUNTY Md. | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| CUMBERLAND | | | SACRED HEART HOSPITAL | | | RAILROADER - FOREMAN | | RAILROAD | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER |
| MARYLAND | | | ALLEGANY | | CUMBERLAND | | YES | | 419 FAYETTE STREET |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | |
| FRANK SHAFFER | | | MARGARET RAHRIG | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | |
| YES | | | 705-09-9848 | | HOSPITAL REOCD, 900 SETON DRIVE, CUMB., MD. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>generalized arteriosclerosis</u>
4409 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____ DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | 1 year |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 4500 | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4-29-1968</u> , to <u>5-21-1968</u> , that (I) (we) last saw the deceased alive on <u>5-21-1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>Lewis Brings</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | | | 22c. DATE SIGNED <u>5-22-68</u> | |
| 22d. PHYSICIAN'S NAME (Type) | | LEWIS BRINGS, M.D. | | | 22e. ADDRESS 57 GREENE STREET, CUMB. MD. 21502 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | May 24, 1968 | | St. Patrick's Cemetery | | Cumberland, Allegany, Md. | | | |
| 24. FUNERAL DIRECTOR ADDRESS James F. Scarpelli, Cumberland, Md. | | | | | 25a. REC'D BY REGISTRAR DATE MAY 29 1968 | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | |

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[illegible]

LEWIS BRIDGES, M.D. 27 GREENE STREET, CHICAGO, ILL. 60606

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 1-54
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | | | | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------|---------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|----------------------------------------------------------------------|--------------------------------------------------------|------|
| 1. DECEASED-NAME
(Type or print) | | First | Middle | Last | 2a. DATE OF DEATH | | 2b. HOUR | | |
| EVELYN | | M. | SHIPPER | | Month 6, Day 1968 | | 2:45PM | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| FEMALE | | WHITE | | 7-14-1912 | | 55 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | Md. |
| W. VA. | | U.S.A. | | | | ALLEGANY | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| CUMBERLAND | | MEMORIAL HOSPITAL | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| MARYLAND | | ALLEGANY | | CUMBERLAND | | | | 810 TROST AVENUE | |
| 14. FATHER'S NAME | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | First | Middle | Last |
| WILLIAM | | H. | OSS | | AUGUSTA | | | RHODES | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | | |
| | | | | MEMORIAL HOSPITAL, CUMBERLAND, MD. | | | | | |
| 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u>
4109 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____ DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
8 days | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4201 | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Wayne C Spiggle MD</u> | | DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> | | MED. DIRECTOR <input type="checkbox"/> | | STAFF PHYS. <input type="checkbox"/> | |
| 22d. PHYSICIAN'S NAME (Type) | | BRADDOCK MEDICAL GROUP | | 22e. ADDRESS | | CUMBERLAND, MARYLAND | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) (State) | |
| Burial | | May 10, 1968 | | Hillcrest Burial Park | | Cumberland Allegany Maryland | | | |
| 24. FUNERAL DIRECTOR | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Philip B. Wendt | | 121 Memorial Ave., Cumb., Md. | | DATE MAY 13 1968 | | Charles Judge | | | |

05-13-58

05-13-58

05-13-58

MAY 6, 1958 2:45P

SHIPPER

AVELYN

2

7-14-1912

WHITE

FEMALE

ALLEGANY

W. Va.

HOSPITAL

CUMBERLAND

310 TRIST AVENUE

ALLEGANY

MARYLAND

BRIDGES

AUGUSTA

ESS

WILLIAM H.

GENERAL HOSPITAL, CUMBERLAND, MD.

CUMBERLAND, MARYLAND

BRADDOCK MEDICAL GROUP

Cumberland Hospital Building

MAY 10, 1958

MAY 10, 1958

WILLIAM H. BRADDOCK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 445 (1)
30M REV. 1-68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------|------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|-----------------------------------------------------------------------------------------|----------------------------------------------------------------------|--------------------------------------|----------------------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | 2b. HOUR | | |
| OLIVER | | | W. SIMONS | | | MAY Month 3 Day 1968 Year | | 7 A. M. | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | |
| MALE | | WHITE | | NOVEMBER 7, 1893 | | 74 YRS. | | MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | Md. | | |
| MARYLAND | | U.S.A. | | | | ALLEGANY | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| FROSTBURG | | | 72 S. WATER STREET | | | ASSI. POSTMASTER | | POST OFFICE | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | |
| STATE MARYLAND | | | ALLEGANY | | FROSTBURG | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 72 S. WATER STREET | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | |
| WILLIAM R. SIMONS | | | CATHERINE WILLIAMSON | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | | |
| | | | 220-44-0474 | | MRS. LILLIE N. SIMONS, FROSTBURG, MD. 21532 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | | | | | | | | Sudden | |
| 431.0 Cerebral hemorrhage | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | | | | | 3 years. | |
| Hypertension | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | |
| Arterio-sclerosis | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | |
| 331X Diabetes Mellitus | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION | | City or Town | | County State | | |
| While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> | | | | Street or R.F.D. No. | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7-1, 1968, to 5-3, 1968, that (I) (we) last saw the deceased alive on 4-29, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE | | H. C. Diehl M.D. | | | | 22c. DATE SIGNED | | 5-3-68 | | |
| 22d. PHYSICIAN'S NAME (Type) | | H. C. DIEHL, M. D. | | | | 22e. ADDRESS | | 39 W. MAIN ST., FROSTBURG, MD. 21532 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) (State) | | |
| BURIAL | | MAY 5, 1968 | | FBG. MEMORIAL PARK | | FROSTBURG, MD. | | | | |
| 24. FUNERAL DIRECTOR | | ADDRESS | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| JOSEPH R. DURST, SR., FROSTBURG, MD | | | | | | DATE MAY 7 1968 | | Charles Judge | | |

MEDICAL CERTIFICATION

0.26

520

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------------------|----------------------------------------------------------------------|----------------------------------------------------------------|
| 1. DECEASED-NAME
(Type or print) | | First | Middle | Last | 2a. DATE OF DEATH | 2b. HOUR |
| WESLEY | | | H. | SLEEMAN | MAY 26, 1968 | 5:45 M |
| 3. SEX | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| MALE | WHITE | | DECEMBER 13, 1885 | | 82 YRS. | |
| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | |
| VALE SUMMIT, MD. | U.S.A/ | | | ALLEGANY Md. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| CUMBERLAND | MEMORIAL HOSPITAL | | RETIRED OPERATOR- LUMBER MILL | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER | | |
| MARYLAND | ALLEGANY | MT. SAVAGE | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | Address | | |
| First Middle Last
WILLIAM SLEEMAN | | First Middle Last
MARGARET MAC FARLAND | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | |
| NO | | 215-10-4390A | | MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u>
4450 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>4501</u>
(b) <u>Arteriosclerotic occlusive disease R leg.</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>years</u> | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>minutes</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>Right above knee amputation</u> | | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 23 May | Sargenere | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>19 April, 1968</u> to <u>26 May, 1968</u> , that (I) (we) last saw the deceased alive on <u>25 May, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
<u>Dr. F. Miltenberger</u> | | 22c. DATE SIGNED
<u>27 May 68</u> | | 22d. PHYSICIAN'S NAME (Type) DR. F. MILTENBERGER | | |
| 22e. ADDRESS
<u>122 SO. CENTRE ST., CUMBERLAND, MD</u> | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | |
| BURIAL | MAY 29 '68 | METHODIST CEMETERY | | MT. SAVAGE, MD. | | |
| 24. FUNERAL DIRECTOR | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| JOSEPH R. DURST, SR., FROSTBURG, MD. 21532 | | DATE MAY 31 1968 | | <u>Charles Judge</u> | | |

08141

08141

20, 1968 5:45

SLEEPING

WESTLEY

WHITE

MALE

ALLEGANY

U.S.A.

VALE SUMMIT, W.V.

MEMORIAL HOSPITAL

CUMBERLAND

ALLEGANY AT SAVAGE

MARYLAND

WAGGONET

SLEEPING

WILKINSON

STATION - MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND

DR. J. WILKINSON

20, 1968

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|------------------------------|-----------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|--|--|--------------------------------------------------------|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN <input checked="" type="checkbox"/> OF ESTI-
DEATH MATED <input type="checkbox"/> | | | 2b. HOUR |
| John Edward Smith | | | | | | Month Day Year | | | 1:50 PM |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN | 2c. DATE PRONOUNCED DEAD | | | 2d. HOUR |
| Male | White | December 16, 1899-68 RS. | | | | Month Day Year | | | 1:50 PM |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | 10. CITY OR TOWN OF DEATH |
| Maryland | | U.S.A. | | | | Allegany Md. | | | Cumberland |
| 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Sacred Heart Hospital | | | Retired - Custodian | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER | | | |
| Maryland | | | Allegany | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 17 North Chase Street | | | |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | |
| John Francis Smith | | | Margaret Elizabeth Whitfield | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | |
| No | | | 212-05-0791 | | Mary S. Brown Smith, 17 N. Chase St., Cumb., Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) _____
DUE TO, OR AS A CONSEQUENCE OF _____
(b) _____
DUE TO, OR AS A CONSEQUENCE OF _____
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
SUDDEN |
| CORONARY OCCLUSION, LEFT | | | | | | | | | |
| CORONARY SCLEROSIS | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
DIABETES MELLITUS | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? | | | |
| | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M.
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE | | | Benedict Skitarelic M.D. | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED |
| EXAMINER'S NAME (Type) | | | Benedict Skitarelic, M.D. | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | May 6, 1968 |
| | | | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| | | | | | | ADDRESS (Street, city, town, or county) | | | Cumberland, Md. |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | May 9, 1968 | | Sts. Peter & Paul Catholic | | Cumberland, Allegany, Md. | | | |
| 24. FUNERAL DIRECTOR | | | Charles E. Haler | | | 25a. REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE |
| | | | Charles E. Haler, 230 Baltimore Ave., Cumb., Md. | | | DATE MAY 9 1968 | | | Charles Judge |

05130

22430

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
300 REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06437

06443

| | | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|
| 1. DECEASED-NAME
(Type or print) First Middle Last
JULIA IRENE SPATES | | | 2a. DATE OF DEATH
Month Day Year
MAY 15, 1968 | | 2b. HOUR
M |
| 3. SEX
FEMALE | 4. RACE
WHITE | 5. DATE OF BIRTH
NOV. 3, 1890 | | 6. AGE (In years last birthday)
77 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)
FROSTBURG, MD. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
ALLEGANY Md. |
| 10. CITY OR TOWN OF DEATH
FROSTBURG | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
33 EAST MAIN STREET | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
HOUSEWIFE | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MARYLAND | | 13b. COUNTY
ALLEGANY | 13c. CITY OR TOWN
FROSTBURG | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME First Middle Last
FRANK SMITH | | 15. MOTHER'S MAIDEN NAME First Middle Last
THERESA FURLONG | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)
N.A. | | 16b. SOCIAL SECURITY NO. A
219-03-8496 | | 17. INFORMANT
FROSTBURG, MD.
MR. WILLIAM SPATES, 78 FROST AVENUE. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic Obstructive Liver Disease
573.9
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 yrs | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
573 X ASCD | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Wayne C. Spiggle | | | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (Type)
WAYNE C. SPIGGLE, M.D. | | | | 22e. ADDRESS
126 N. SMALLWOOD ST., CUMBERLAND, MD. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE
MAY 18, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
ST. MICHAEL'S CEM. | |
| 23d. LOCATION (City or Town) (County) (State)
FROSTBURG ALLEGANY, MD. | | 23e. REC'D BY REGISTRAR
MAY 22 1968 | | | |
| 23f. FUNERAL DIRECTOR
MARILOU M. SOWERS | | 23g. ADDRESS
HOME, 60 W. MAIN, FROSTBURG | | 23h. REGISTRAR'S SIGNATURE
Charles Judge | |

152

4785

VIII

...A.P. 7.2. OR. 1917. 1917.

57425239

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06438

06444

| | | | | | | | | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|-----------------------------------------------------------------------------------------------------------|--|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|----------------------------------------------------------------------------------------------|--|--|
| 1. DECEASED-NAME (Type or print) MARY | | | First Middle Last E. STAFFORD | | | 2a. DATE OF DEATH
Month 5 Day 9 Year 68 | | | 2b. HOUR M | | |
| 3. SEX FEMALE | | | 4. RACE WHITE | | | 5. DATE OF BIRTH 5-27-10 | | | 6. AGE (In years last birthday) 57 YRS. | | |
| 7a. BIRTHPLACE (State or foreign country) MARYLAND | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH ALLEGANY Md. | | |
| 10. CITY OR TOWN OF DEATH CUMBERLAND | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, or if retired.) HOUSEWIFE | | | 12b. KIND OF BUSINESS OR INDUSTRY HW | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD | | | 13b. COUNTY ALLEGANY | | | 13c. CITY OR TOWN CUMBERLAND | | | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | |
| 14. FATHER'S NAME First Middle Last FRANK HUMBERTSON | | | 15. MOTHER'S MAIDEN NAME First Middle Last MYRTLE KING HUMBERTSON | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or not known <input checked="" type="checkbox"/> (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. 220 40 1149 | | |
| 17. INFORMANT 900 SETON DRIVE Address | | | 17. INFORMANT SACRED HEART HOSPITAL CUMBERLAND, MD. 21502 | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARCINOMATOSIS
1830 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) CARCINOMA OF OVARY
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
1750 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year 19 P.M. | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from FEB , 19 68 , to 9 MAY , 19 68 , that (I) (we) last saw the deceased alive on 9-MAY 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE L. Michael Gene DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | | | | 22c. DATE SIGNED 5-10-68 | | |
| 22d. PHYSICIAN'S NAME (Type) DR. MICHAEL GLICK | | | | | | 22e. ADDRESS 126 N. SMALLWOOD STREET CUMBERLAND, MARYLAND | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE 5-12-68 | | | 23c. NAME OF CEMETERY OR CREMATORY Pleasant Grove Cemetery | | | 23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Maryland | | |
| 24. FUNERAL DIRECTOR H. Lee Silcox 404 Decatur St., Cumb., Md. ADDRESS | | | | | | 25a. REC'D BY REGISTRAR MAY 13 1968 DATE | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | |

MEDICAL CERTIFICATION

00444

00444

2 2 2

STAFFORD

NOV

27

2-27-10

WHITE

FILE

ALLEGIA

120

NOV

HM

HOSPITAL

RECORDS DEPT HOSPITAL

RECORDS DEPT

200 NUMBERED RECORDS

CONFIDENTIAL

ALLEGIA

NO

BY THE KING HOSPITAL

HOSPITAL

RECORD

NO

100 11, 24, 11, 24, 11, 24

CONFIDENTIAL, NO. 11, 24, 11, 24

DR. MICHAEL CLICK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

1
06439

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06445

| | | | | | | | | | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------|--------|----------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|----------------------------------------------------------------------|--------------------------------------|-----------------------|----------------------------------------------|--|
| 1. DECEASED-NAME
(Type or print) | | First | Middle | Last | 2a. DATE OF DEATH | | 2b. HOUR | | | | |
| JAMES | | BARR | STEELE | May 24 1968 | | 11:15 PM | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| MALE | | WHITE | | 10-4-1883 | | 84 YRS. | | MONTHS | | DAYS | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| LONACONING, MD. | | USA | | | | ALLEGANY COUNTY Md. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| CUMBERLAND | | MEMORIAL HOSPITAL | | FARMER | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | | |
| MD. | | ALLEGANY | | CRESAPTOWN | | | | WARRIOR DRIVE | | | |
| 14. FATHER'S NAME | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | First | Middle | Last | | |
| JOHN | | | | STEELE | JEANIE | | | FILLON | XXXXXXXXXX | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | | | | |
| NO | | 231-24-5064 | | Mrs. Jean Leake, Warrior Dr., Cresaptown, Md. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Right Sided Heart Failure with Pulmonary Effusion</u> | | | | | | | | | | | |
| 4129 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | |
| (b) <u>Arteriosclerotic Cardiovascular Disease</u> | | | | | | | | | | 1 week | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 4221 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>May 23</u> , 19 <u>68</u> , to <u>May 24</u> , 19 <u>68</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>May 24</u> , 19 <u>68</u> and that in (my) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above, (I) (<u>we</u>) (<u>did not</u>) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> | | MED. DIRECTOR <input type="checkbox"/> | | STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (Type) | | 133 VIRGINIA AVE., CUMBERLAND, MD. | | 22e. ADDRESS | | 5-27-68 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | | |
| Burial | | 5/27/68 | | Frostburg Memorial Park | | Frostburg, Allegany, Md. | | | | | |
| 24. FUNERAL DIRECTOR | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| Charles E. Hafer | | 280 Balto. Ave, Cumb., Md. | | DATE | | MAY 29 1968 | | | | | |

05242

05242

JAMES STEELE MAY 28 1969 11:15

MALE WHITE 10-4-1983

LOHANNING, MO. USA ALLEGANY COUNTY

CUMBERLAND MEDICAL HOSPITAL

ALLEGANY - CRESSKOPF, X

JOHN STEELE JEROME STEELE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper (pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV. 1/68

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|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|------------------------------------------------------------------------------------------------------|--|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|----------------------------------------------------------------------------------|-------------------------------------------------|--|-----------------------------------|--|--|--------------------------|--|--|--------------|--|----------------------------------------------------|-------------------|--|--|--|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Item# 14, Film# 401 6/21/68km | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First
BABY | | | Middle
BOY | | | Last
SWISHER | | | 2a. DATE OF DEATH
Month
MAY | | | Day
20 | | | Year
1968 | | | 2b. HOUR
11:15 | | | | | | | | |
| 3. SEX
MALE | | | 4. RACE
WHITE | | | 5. DATE OF BIRTH
MAY 20, 1968 | | | 6. AGE (In years
lost birthday)
YRS. | | | IF UNDER 1 YEAR
MONTHS | | | IF UNDER 24 HRS.
DAYS | | | HOURS | | | MIN. | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign
country)
MD. | | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
ALLEGANY | | | Md. | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
CUMBERLAND | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street and no.)
MEMORIAL HOSPITAL | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE
MD. | | | 13b. COUNTY
ALLEGANY | | | 13c. CITY OR TOWN
CUMBERLAND | | | 13d. INSIDE CITY LIMITS?
<input type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME
First
Frank | | | Middle
JAMES | | | Last
H. SWISHER | | | 15. MOTHER'S MAIDEN NAME
First
MARY | | | Middle
B. | | | Last
DAWSON | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(If yes give war or dates of service)
No | | | 16b. SOCIAL SECURITY NO.
None | | | 17. INFORMANT
MEMORIAL HOSPITAL, CUMBERLAND, MD. | | | Address | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Prematurely 22 weeks</u>
761.5
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
lost. | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>776x Motor Vehicle Accident March 1968</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last
saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Dr. F. B. Whitworth</u>
22b. PHYSICIAN'S
NAME (Type)
DR. F. B. WHITWORTH | | | | | | | | | | 22c. DATE SIGNED
5/22/1968 | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial | | | 23b. DATE
5/27/1968 | | | 23c. NAME OF CEMETERY OR CREMATORY
Freedom Memorial Park | | | 23d. LOCATION (City or Town) (County) (State)
Cumberland Alleg Md | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
<u>John J. Hafner, Jr.</u>
John J. Hafner, Jr. 230 Balto Ave. Cumberland Md | | | | | | | | | | 25a. REC'D BY REGISTRAR
MAY 27 1968 | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | | | | | | | |

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BOY SWISHER MAY 1968

DATE MAY 20 1968

ALBANY

ALBANY

ALBANY

ALBANY

JAMES

SWISHER

MAY

ALBANY

MEMORIAL HOSPITAL, ALBANY, N.Y.

James B. Swisher

Motor Vehicle Accident Insurance

James B. Swisher

DR. J. B. SWISHER, JR.

MAY 21 1968

Page 4 may be retained by the hospital or offending physician.

VR A15 (4)
FORM REV. 1/6

MEDICAL CERTIFICATION

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------|--------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|----------------------------------------------------------------------|----------------------------------------------|----------|
| Item 13 taken from birth certificate | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR |
| JOHN | | | EDWARD | | | 5 Month 22 Day 68 Year | | | 12:40 PM |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | 7. YRS. |
| MALE | | WHITE | | 5-8-1968 | | | 14 | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| CUMBERLAND, MD. | | U. S. A. | | | | ALLEGANY Md. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| CUMBERLAND | | MEMORIAL HOSP. | | Infant | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | |
| W. VA. | | ALLEGANY | | RIDGELEY CUMBERLAND | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | ROUTE #11 Scenic Lane | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | Address | | | |
| First Middle Last | | | First Middle Last | | | | | | |
| JOHN A? TAYLOR | | | EVELYN M. WELSH | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | |
| No | | | None | | MEMORIAL HOSPITAL- CUMBERLAND, MD. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) 7589 CARDIAC FAILURE | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (b) MULTIPLE CONGENITAL ANOMALIES | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 7593 | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the cause stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | | 22c. DATE SIGNED | | | | |
| DR. ROBERT BRODELL | | | | | 5/23/1968 | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | 22e. ADDRESS | | | | |
| DR. ROBERT BRODELL | | | | | 500 GREENE STREET, CUMBERLAND, MD. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 5/27/1968 | | Freedom Memorial Park | | Cumberland Alleg Md. | | | |
| 24. FUNERAL DIRECTOR | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| John J. Hafer, Jr., 230 Balto Ave. Cumberland Md | | | | | MAY 27 1968 | | Charles J. J... | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (Rev. 1-58)
30M REV. 1-58

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|-----------------------------------------------------------|--|--------------------------------------------------------------|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) GEORGE S. THOMAS | | | 2a. DATE OF DEATH
Month 5 Day 12 Year 68 | | | 2b. HOUR 8:35 MIN. M | | | | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
5-4-1921 | | 6. AGE (In years last birthday)
47 | | 7. IF UNDER 1 YEAR
MONTHS 0 DAYS 0 | | | |
| 7a. BIRTHPLACE (State or foreign country)
PA. | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
ALLEGANY | | | | | |
| 10. CITY OR TOWN OF DEATH
CUMBERLAND | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
MEMORIAL HOSPITAL | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
ENGINEER | | 12b. KIND OF BUSINESS OR INDUSTRY
B & O R R | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MARYLAND | | 13b. COUNTY
ALLEGANY | | 13c. CITY OR TOWN
CUMBERLAND | | 13d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 13e. STREET AND NUMBER
ALGONQUIN HOTEL | | | |
| 14. FATHER'S NAME
First LIVISTON Middle THOMAS Last THOMAS | | | 15. MOTHER'S MAIDEN NAME
First ANNA Middle BELLE Last RICHTER | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) YES | | 16b. SOCIAL SECURITY NO.
WW 2 | | 17. INFORMANT
MEMORIAL HOSPITAL - CUMBERLAND, MD. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
4109 IMMEDIATE CAUSE (a) Coronary Thrombosis
DUE TO, OR AS A CONSEQUENCE OF Coronary artery disease of 2 previous infarctions 2 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(c) Sclerosis Coronaria | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 hr. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4201 | | | | | | | | | | | |
| 19a. DATE OF OPERATION
5/11/68 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
4201 | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
NO | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner)
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> of work <input type="checkbox"/> | | 21b. TIME OF INJURY
HOUR A.M. 5:30 Month 5 Day 11 Year 1968
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
Stroke | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> of work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
Home | | 21f. LOCATION Street or R.F.D. No. 122 S. CENTRE ST., City or Town CUMBERLAND, County ALLEGANY State MD. | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/11/68 , 19 68 , to 5/12/68 , 19 68 , that (I) (we) last saw the deceased alive on 5/11/68 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
DR. R. J. WILLIAMS | | 22c. DATE SIGNED
5/12/68 | | 22d. PHYSICIAN'S NAME (Type)
DR. R. J. WILLIAMS | | | | | | | |
| 22e. ADDRESS
122 S. CENTRE ST., CUMBERLAND, MD. | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
5/15/1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Zion Memorial Park | | 23d. LOCATION (City or Town) (County) (State)
Near Cumberland Alleg Md. | | | | | |
| 24. FUNERAL DIRECTOR
John J. Hafer, Jr. | | 25a. REC'D BY REGISTRAR
Charles Judge | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | 25c. DATE
MAY 15 1968 | | | | | |

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06448

06449

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | | | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|--------------------------|--|----------------------------------------------|--|
| 1. DECEASED-NAME
(Type or Print) | | First | | Middle | | Last | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Month Day Year | | | | 2b. HOUR | |
| George | | Evers | | Turner | | MAY 25, 1968 | | | | 10 P M | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | 2c. DATE PRONOUNCED DEAD | | 2d. HOUR | |
| Male | White | April 26, 1891 | | 77 YRS. | | | | | | MAY 25, 1968 | | 10 P M | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | | | |
| W. Va. | | USA | | | | Allegany | | | | | | Md. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| Cumberland | | Memorial Hospital | | Retired Carpenter | | Carpenter | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | | | | | |
| W. Va. | | Mineral | | Ridgeley | | | | RFD# 1 | | | | | |
| 14. FATHER'S NAME | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME | | First | | Middle | |
| William | | Turner | | | | | | Mary | | E. | | Veach | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | RFD# ADDRESS | | | | | | | |
| No | | 213-18-2102 | | Mrs. Rebecca Turner Ridgeley, W. Va. | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION | | | | | | | | | | | | SUDDEN | |
| 4109 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | |
| (b) CORONARY SCLEROSIS | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) | | | | | | | | | | | | | |
| 4201 | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M.
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>Benedict Skitarelic</i> M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | 22b. DATE SIGNED | | | | | |
| EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D. | | | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | | May 25, 1968 | | | | | |
| | | | | ADDRESS (Street, city, town, or county) CUMBERLAND, MARYLAND | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | |
| Burial | | May 29, 1968 | | Abe Cemetery | | RFD#1 Ridgeley Mineral, W. Va. | | | | | | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| H. Lee Silcox 404 Decatur St., Cumb., Md. | | | | | | DATE MAY 28 1968 | | <i>Charles Judge</i> | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| CERTIFICATE OF DEATH | | | | | |
| 1. DECEASED-NAME (Type or print) | | 2a. DATE OF DEATH | | 2b. HOUR | |
| BABY BOY WAGONER | | Month 5 Day 30 Year 68 | | 8:45 AM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | |
| MALE | | WHITE | | 5-30-68 | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| MARYLAND | | U.S.A. | | 9. COUNTY OF DEATH | |
| CUMBERLAND, | | MEMORIAL HOSPITAL | | ALLEGANY Md. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | |
| CUMBERLAND, | | MEMORIAL HOSPITAL | | none | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) | | 13b. COUNTY | | 13c. CITY OR TOWN | |
| STATE WEST. VA. | | 13b. COUNTY | | FT. ASHBY | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| JOHN D WAGONER | | MABEL L. LEWIS | | 13e. STREET AND NUMBER | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| no | | none | | MEMORIAL HOSPITAL | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | |
| PART I. DEATH WAS CAUSED BY: | | PART I. DEATH WAS CAUSED BY: | | PART I. DEATH WAS CAUSED BY: | |
| IMMEDIATE CAUSE (a) | | IMMEDIATE CAUSE (a) | | IMMEDIATE CAUSE (a) | |
| 7969 | | 7969 | | 7969 | |
| DUE TO, OR AS A CONSEQUENCE OF | | DUE TO, OR AS A CONSEQUENCE OF | | DUE TO, OR AS A CONSEQUENCE OF | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | | | | |
| 22c. DATE SIGNED | | | | | |
| June 1, 1968 | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | |
| DR. OLIVER H. NADEAU | | | | | |
| 22e. ADDRESS | | | | | |
| CUMBERLAND, MD. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | June 1, 1968 | | Fort Ashby Cemetery | |
| 23d. LOCATION (City or Town) (County) (State) | | 23d. LOCATION (City or Town) (County) (State) | | 23d. LOCATION (City or Town) (County) (State) | |
| Fort Ashby, W. Va. | | Fort Ashby, W. Va. | | Fort Ashby, W. Va. | |
| 24. FUNERAL DIRECTOR | | 24. FUNERAL DIRECTOR | | 24. FUNERAL DIRECTOR | |
| James F. Scarpelli, Cumberland, Md. | | James F. Scarpelli, Cumberland, Md. | | James F. Scarpelli, Cumberland, Md. | |
| 25a. REC'D BY REGISTRAR | | 25a. REC'D BY REGISTRAR | | 25a. REC'D BY REGISTRAR | |
| DATE JUN 7 1968 | | DATE JUN 7 1968 | | DATE JUN 7 1968 | |
| 25b. REGISTRAR'S SIGNATURE | | 25b. REGISTRAR'S SIGNATURE | | 25b. REGISTRAR'S SIGNATURE | |
| [Signature] | | [Signature] | | [Signature] | |

DEPT.

DATE

06120

BABY

BOY

WAGONER

MALE

WHITE

2-10-04

CLINICAL

1.1.1.

ALLEGANY

CLINICAL

MEMORIAL HOSPITAL

BOX 373

FT. CHASE

JOHN

WAGONER

ROBERT

LEWIS

MEMORIAL HOSPITAL

CHESBOND, MD.

DR. OLIVER H. HADLEY

CLINICAL, MD.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06445

06451

| | | | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| 1. DECEASED-NAME
(Type or print) First Middle Last
THELMA S. WOLFORD | | | 2a. DATE OF DEATH
Month Day Year
MAY 11 1968 | | 2b. HOUR
9:58 PM |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
SEPT. 11, 1913 | |
| 7a. BIRTHPLACE (State or foreign country)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 6. AGE (In years last birthday)
54 YRS. | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
ALLEGANY | | 12b. KIND OF BUSINESS OR INDUSTRY
Paper Mill | |
| 10. CITY OR TOWN OF DEATH
CUMBERLAND, MD. | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
SACRED HEART HOSP. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Cutter Operator | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MARYLAND | | 13b. COUNTY
ALLEGANY | | 13c. CITY OR TOWN
BARTON | |
| 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | | |
| 14. FATHER'S NAME First Middle Last
WELTY HAMILTON | | 15. MOTHER'S MAIDEN NAME First Middle Last
HAMILTON ANNA HAMILTON | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown NO (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
213-22-4913 | | 17. INFORMANT
HOSPITAL RECORD | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 2000 Necrotizing enteritis
DUE TO, OR AS A CONSEQUENCE OF
(b) Arteriomatous leak
DUE TO, OR AS A CONSEQUENCE OF
(c) Adenocarcinoma of mesentery
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
2000 Extensive abdominal irradiation | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
8 days
10 days
18 mos. |
| 19a. DATE OF OPERATION
31 68 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
Hour A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to 11 May, 1968 , that (I) (we) last saw the deceased alive on 11 May, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
F. Miltenberger | | | | 22c. DATE SIGNED
16 May 68 | |
| 22d. PHYSICIAN'S NAME (Type)
F. MILTENBERGER, M.D. | | | | 22e. ADDRESS
122 S. CENTRE ST., CUMBERLAND, MD. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
May 15, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Philos Cem. | |
| 23d. LOCATION (City or Town) (County) (State)
Westernport Allegany Md. | | 23e. REC'D BY REGISTRAR
Charles Judge | | | |
| 24. FUNERAL DIRECTOR
BOAL'S FUNERAL HOME-111 CHURCH ST., WESTERNPORT | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

